Final Report to the Legislature: Compilation of Findings on Provider Rate Evaluations and Availability of Services in the Medicaid Fee-for-Service Program

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EXECUTIVE SUMMARY

The Office of the Legislative Auditor (OLA) issued a February 2008 report "Financial Management of Health Care Programs" which covered, among other items, state payment rates for health care programs. The OLA concluded in its report that the Legislature and the Department of Human Services (DHS) have not taken sufficient steps to address concerns about the adequacy and equity of Minnesota's fee-for-service rates. Specifically, the OLA recommended:

- DHS should report to the 2009 Legislature on the adequacy of Minnesota's fee-for-service provider rates. As part of this analysis, DHS should identify service areas or regions of the state in which public program enrollees have had difficulty accessing providers.

- This report must include recommendations to increase rates as needed to eliminate identified access problems.

- The Legislature should consider increasing fee-for-service payment rates for certain types of providers, such as primary care physicians.

Background

Other than a one-time across the board increase of 3% in 2000, physicians in the fee-for-service (FFS) program have not received a rate increase since the rates were originally set in 1992. The 1992 fee-for-service rates were set at the median 1989 physician charges reduced by 20% (for most primary care services) or 25% (all other services). Since there have been essentially no rate adjustments since 1992, payments for office visits, maternity care and preventive medicine have deteriorated to 33% of charges (versus 62% in 1993) and to 31% of charges (versus 58% in 1993) for other physician services. Some mental health services have received a 23.7% increase in addition to the 3% increase when the mental health service is provided by a psychiatrist.

In December 2008, the DHS retained Burns & Associates, Inc. (B&A), a health care consulting firm who works primarily with state Medicaid agencies, to perform an independent evaluation of the fee-for-service provider rates. B&A was charged to:

1. Compare the FFS provider rates paid by DHS to other states' Medicaid rates

2. Examine FFS rates paid to physicians and non-physicians who deliver the same service

3. Investigate the availability of providers to FFS participants, with a focus on physician services, and report the results by region and provider specialty to determine if FFS payment rates are influencing participants' availability to practitioners

4. Survey physicians and beneficiaries in the Minnesota Health Care Program (the FFS program) and report on perceptions of limitations in beneficiaries' access to care as a result of the current fee structure

A separate report was generated for each of these analyses. The reports appear as Appendices A through D which accompanies this final report. The body of this report summarizes information from each individual report.

Findings

Related to Minnesota's FFS rates compared to other states' Medicaid programs and Medicare

The fee-for-service base rates from nine states (Iowa, Indiana, Michigan, Nebraska, Ohio, Oregon, Washington, Wisconsin and Vermont) were compared to Minnesota's for 102 high volume unique services billed by physicians.

1. The ten state comparison revealed that Minnesota's Medicaid fee-for-service rates were:
    a. Lowest among the 10 for office/outpatient visits
    b. Lower than 7 out of 10 for emergency and critical care services
    c. Lowest among the 10 for rates paid to pediatricians for office/outpatient visits (rates paid for Early Periodic Screening, Diagnosis and Treatment (EPDST) are not included here)
    d. Lower than all but one state for OB/GYN services
    e. Lower than 7 out of 10 for dental services
    f. In the middle of the states for psychiatry and cardiology
    g. Highest or near highest for selected neurology services
    h. Highest among the 10 for orthopedic surgery services

2. A 2003 study reported that Minnesota paid physicians at 79% of the Medicare rates (all services), which was higher than the national average of 69%. But primary care services were paid at 64% of the Medicare rates (compared to the national average of 62% across all Medicaid agencies). In a 2007/2008 study of selected pediatric rates, Minnesota paid at approximately 50% of Medicare and at approximately 80% of the comparison states.

A limitation of these findings is the fact that Minnesota's DHS is not unusual among Medicaid agencies nationwide in that a payment rate is placed on file for a particular service (often called the "base rate") but there may be adjustments—both upward and downward—to the base rate in certain circumstances. These adjustments typically are a result of legislation targeting changes in payments to specific provider types or for specific services. This "special pricing" is usually not reflected in a state's published fee schedule and thus is not transparent to providers. The base rate on file is only the starting point of the pricing calculation. What is unknown from each state surveyed is the level of special pricing that is used to make upward or downward adjustments. This is because the special pricing is often conditional in nature and cannot be quantified across-the-board.

Related to FFS rates paid for services provided and billed by both physicians and non-physicians

3. There were 21services provided in sufficient volume by both physicians and non-physicians in the two-year period studied. The nonphysicians billing these services were various types of nursing professionals. Among these 21 services, only 10 were of significant volume among the nursing providers (i.e. payments above $100,000 in the two-year period).

4. In six of the 10 high-volume cases, the nurse provider was paid, on average, higher than the physician. This is not because the published rate on file is higher for the nurse than it is for the physician. Rather, it is due to special pricing adjustments mandated by the legislature over the years that adjust the base rate on file depending on the provider specialty and/or the location where the service was provided. Payments for the 10 services where the physician rate was lower than the nonphysician rate represented only 10.3% of total physician payments in State Fiscal Years 2007 and 2008.

Related to physician participation in Medicaid fee-for-service and rates

5. An analysis revealed areas of the state where physician participation in the Medicaid fee-for-service program is low, but did not reveal a direct linkage between low physician availability in specific regions and lower access to services by members. The analysis also revealed opportunities to increase physician participation at the county level.
    a. Only 55% of the physicians with Medicaid fee-for-service contracts could be classified as "actively participating" in the program. For this study, "actively participating" is defined as physicians who billed the Medicaid FFS program on average more than three times per month.
    b. Many "less actively-participating" physicians (those who billed the Medicaid FFS program but less than three times per month on average) could be contracting with the FFS program because of the requirement to do so in order to participate in the state employee benefits program.

6. There are over 2,000 of physicians with Medicaid managed care contracts that do not participate in the FFS program.

7. Based on a ratio of physicians to FFS members:
    a. Urban areas in Minnesota have "high" (one to 100 FFS participants per physician) or "medium" (101 to 500 FFS participants per physician) availability among the "actively participating" pool of physicians
    b. Ten rural counties have "low" (more than 500 FFS participants for every physician) availability among this pool of physicians
    c. Four rural counties have no availability (i.e., no providers)

8. When examining a larger pool of physicians (i.e., including the "less actively-participating" and the Medicaid managed care physicians), two rural counties (Benton and Dodge) would have "low" availability.

9. Low provider availability does not appear to equate to low access, however. Evidence supporting this finding includes:
    a. Among the 14 counties in the state designated as "low" or "no" primary care availability in the county for FFS participants, only one county had higher ER utilization (measured on a per 1,000 FFS member basis) than the statewide average. However, this county (Mahnomen) also had higher primary care utilization per 1,000 members as well.
    b. Besides Mahnomen County, for the other 13 counties with low provider availability, one county had similar primary care utilization as the statewide average, six counties had somewhat lower utilization, and six counties had much lower utilization. This indicates that efforts could be made in select counties in improve provider availability to members.

Related to the Physician Survey

10. When asked to estimate the level that the rates would need to be increased to cover their costs to deliver the services to Medicaid FFS members, over one quarter (28%) of the respondents indicated that the rates would need to at least be doubled, while over 80% stated that the rates needed to be increased by 40 percent or more.

11. When asked for their satisfaction level about the rates shown on the survey's rate schedule, 89% of the respondents expressed some level of dissatisfaction with the rates and 73% were very unsatisfied. No respondent indicated that they were 'very satisfied' with the rates for high-volume services.

12. Physicians were asked to provide satisfaction levels of rates paid by payer. The Medicaid FFS program had the highest level of dissatisfaction (77% very unsatisfied and 13% somewhat unsatisfied), but the Medicaid managed care program was at almost the same level of dissatisfaction (70% very unsatisfied and 20% somewhat unsatisfied). Physicians rated high satisfaction levels with commercial managed care rates (74% very or somewhat satisfied) as well as with non-managed care commercial rates (81%).

Related to the Member Survey

13. 87% of members have a personal doctor or nurse they see most of the time.

14. Almost two-thirds of the respondents had seen their primary doctor three or more times during a recent nine-month period. More than half had seen another physician in the practice where their primary doctor works. More than half had also visited another doctor's office or clinic during this time period (such as a specialist).

15. Over half of the members were able to obtain an appointment with their primary doctor when they needed care right away within one day and over three-quarters were able to obtain an appointment within two days. About half of members said that they could obtain a routine appointment within a week either at their primary doctor's office or at another doctor's or clinic office.

16. Although 40% of the respondents stated that they had used the hospital emergency room if they needed care right away, the majority of these members had only used the ER once or twice in the last nine months. B&A found a disproportionately higher response for ER usage among members in the Northeast Region of the state.

17. Members were asked the level of difficulty in finding different physician specialty types as well as dentists. Eighty percent of the respondents indicated no problem in finding a personal doctor or nurse, but only 54 percent indicated no problem in finding a dentist. When analyzed at the regional level, the difficulty in finding a dentist was concentrated in the northern and central parts of the state.

18. Over 60% of survey respondents stated that they were 'very satisfied' and over 80% were either 'very satisfied' or 'somewhat satisfied' with the services they receive in the Medical Assistance program. Almost three-quarters of respondents (73%) believe that their ability to receive care in the Medical Assistance program is either the same or better than what they would receive with private insurance.

Recommendations

After the comparison of the DHS rates to other states' Medicaid fee-for-service programs, a comparison of rates paid to physicians and non-physicians who deliver the same service, physician availability to Medicaid members at the county level, and feedback from the physician and beneficiary surveys, B&A recommends the following:

1. The DHS should adopt the Medicare Resource-Based Relative Value Scale (RBRVS) as per Legislative mandate. Resources should be put towards implementation of this system as a base for further rate changes.

   Implemented in 1992, the Medicare RBRVS is a methodology that is based on three factors of "resource use": physician effort, practice expense and professional liability insurance. The resource use factors (called relative value units, or RVUs) for each service are multiplied by a standard "conversion factor" that is a dollar amount, to produce a reimbursement rate for each service. The resource use factors for specific services are reviewed annually by a committee that includes the American Medical Association, among other organizations, to ensure that the factors reflect current practices. The "conversion factor" is reviewed and may be adjusted by Medicare annually.

   The RBRVS system is a national standard of reimbursement that virtually all physicians understand, is regarded as having consistent resource use factors for the various physician services, and is relatively easy to administer. Implementation of an RBRVS system will create a base for consistency and the ability to make modifications that will be inherently more logical than the current FFS rate system. If the RBRVS is adopted, Minnesota should annually update the RVUs to coincide with Medicare's changes.

2. In adopting the RBRVS, the state should carefully consider the level it sets for the "conversion factor" used in the methodology. Numerous policy goals can be achieved through the adjustment of the conversion factor. For example:

   a. Since it is unlikely in the current economic situation that the state can afford physician payments at the Medicare rates, the conversion factor should be set at a level that will be budget neutral overall. Although certain services will enjoy increases while others will experience decreases, consistency in compensation between physician services will be achieved.

   b. If additional funding is available, this funding should be directed to services that the state values as a policy matter. This can be achieved by adopting a higher conversion factor for these "high value" services. B&A recommends the state first direct any additional funding to evaluation and management physician services to encourage participation among primary care physicians and to reduce inappropriate ER use. This recommendation is supported in the feedback from the provider survey, where the majority of physicians that provided specific recommendations for rate increases suggested high-volume evaluation and management services should be a priority.

   c. If the state wishes to differentiate between provider specialties (e.g., physicians and non-physicians) or by areas of the state, these goals can also be achieved through an adjustment in the conversion factor. In such cases, the conversion factor would differ depending on the provider type or the provider location.

   d. The state should adopt a policy goal of compensating physicians at a specified level of the Medicare rates. B&A recommends a target of 85% of the Medicare rates. As funding becomes available, the generally applied conversion factor can be increased.

3. In adopting the RBRVS, the state should explicitly state its policy goals and limit adjustments in the claims payment process to these goals. Any adjustments should be made transparent to providers. Publishing different conversion factors that may be implemented will eliminate much of the oblique pricing strategies currently in place.

SECTION I: BACKGROUND

The Minnesota Department of Human Services (DHS), Health Services and Medical Management Division (HSMMD) retained Burns & Associates, Inc. (B&A) to evaluate the adequacy of current rates and the availability of services (primary care and selected specialties) for fee-for-service (FFS) participants enrolled in the Minnesota Health Care Program (MHCP).

B&A is an independent health care consulting firm who works primarily with state Medicaid programs. Under this engagement, B&A was tasked with completing separate reports at the request of the DHS that are synthesized in this summary report. Each of the stand-alone reports appears in the appendix to this summary report, with the exception of the report of results of the provider and member surveys, which will be delivered on April 30. The stand-alone reports include:

- Report to the Legislature: Comparison of Minnesota Medicaid Fee-for-Service Physician Rates to Rates Paid by Medicare and Selected Other States (summarized in Section II of this compilation report)

- Report to the Legislature: Comparison of Payment Rates for Services Delivered by Physicians and Non-Physicians in the Medicaid Fee-for-Service Program (summarized in Section III of this compilation report)

- Report to the Legislature: Evaluation of Availability of Physician Services in the Minnesota Medicaid Fee-for-Service Program (summarized in Section IV of this compilation report)

A briefing of the methodology related to the provider and member survey release appears in Section V of this compilation report. The final report of survey results will be delivered on April 30. B&A's recommendations resulting from our analysis appear in Section VI.

DHS is required to provide this report as a result of the Office of the Legislative Auditor's (OLA) February 2008 report "Financial Management of Health Care Programs[1]." In Chapter 3 of the report, "State Payment Rates for Health Care Programs," the OLA concluded that the Legislature and the DHS have not taken sufficient steps to address concerns about the adequacy and equity of Minnesota's fee-for-service rates. Specifically, the OLA recommended:

- DHS should report to the 2009 Legislature on the adequacy of Minnesota's fee-for-service provider rates. As part of this analysis, DHS should identify service areas or regions of the state in which public program enrollees have had difficulty accessing providers.

- The Legislature should consider increasing fee-for-service payment rates for certain types of providers, such as primary care physicians.

Minnesota's physicians are paid for services delivered to the FFS (non-managed care) population at the lower of either:

1. Their submitted charge, or

[1] The OLA report can be found at: http://www.auditor.leg.state.mn.us/ped/pedrep/healthcare.pdf

2. The median rate established in 1992 using 1989 data that is discounted 20% (for evaluation and management or OB/GYN services) or 25% (for all other services).

Other than a one-time across the board increase of three percent in 2000, physicians have not received rate increases since the 1989 base year data was utilized. Since there have been essentially no rate adjustments since 1992, payments for office visits, maternity care and preventive medicine have deteriorated to 33% of charges (versus 62% in 1993) and to 31% of charges (versus 58% in 1993) for other physician services. Some mental health services have received a 23.7% increase in addition to the three percent increase when the mental health service is provided by a psychiatrist.

This report focuses solely on the FFS population and not the Medicaid managed care population. Also, although other provider types are identified in the OLA report, this report focuses exclusively on physicians.

SECTION II: SUMMARY OF THE REPORT COMPARING MINNESOTA MEDICAID FEE-FOR-SERVICE PHYSICIAN RATES TO RATES PAID BY MEDICARE AND OTHER STATE MEDICAID AGENCIES

Appendix A provides a detailed review of Minnesota's fee-for-service (FFS) rates compared to other selected states. This section summarizes the methodology used to compare Minnesota's rates to other states as well as summary exhibits which present each comparison state's rates as a percentage of the Minnesota rate.

Methodology

The methodology for collecting and comparing physician rates consisted of four steps: Selection of comparison states, selection of comparison physician services, development and administration of a survey instrument, and collection of state Medicaid rates outside of the survey.

Selection of Comparison States

Comparison states were selected using various criteria which included comparing Minnesota to other states against particular benchmarks or because they were requested by the state for inclusion.

- Four states were selected for comparison based on recommendations of the Health Services and Medical Management Division (HSMMD): Michigan, Oregon, Washington and Wisconsin.
- Two states were selected because their physician rates (as a percentage of Medicare rates) were at least 10 percentage points higher than Minnesota: Iowa and Nebraska.
- Another two states had physician rates at least 10 percentage points lower than Minnesota: Indiana and Ohio
- B&A added a ninth state, Vermont, because its Medicaid program is about to initiate a physician rate study of its own.

Selection of Comparison Physician Services

In order to determine which services would be compared between the states, B&A examined the Minnesota Medicaid claims file for services delivered to FFS beneficiaries during the period July 1, 2006 through June 30, 2008. Claims were sorted by the specialty associated with the treating physician. High-volume services (based on number of units billed and total payments) were selected to compare to other states. In total, 67 unique physician codes were selected that included codes billed by primary care providers, pediatricians, OB/GYNs, psychiatrists, neurologists, orthopedic surgeons and cardiologists. Some codes were used by multiple specialties. At the request of HSMMD, 11 high-volume dental service codes were also included for comparison.

The physician codes selected for comparison accounted for 44.6% ($134.2 million) of the $302 million paid to physicians over the two years through the FFS program and the dental codes selected accounted for 39.9% ($23.3 million) of the $58 million paid to dentists over the two years through the FFS program.

Developing and Administering the Survey

To gather data from the comparison states for the analysis, B&A prepared a short survey that asked for rate and programmatic information. The desired rate-related information included: basis for rate development, total annual payments by code, total annual service units by code, and per member per month (PMPM) service units and dollars. The programmatic information included any available evaluations of physician participation rates and any evaluations or anecdotal information on access to care issues, including out of state referrals.

Prior to distributing the survey, B&A identified contacts from each state and discussed the survey with them. The fee portion of the each survey was populated with each state's fee schedule (as found on the Internet) and, for rates paid to pediatricians, information from the annual survey conducted by the American Academy of Pediatrics[2]. The surveys were then distributed to the states with a request for confirmation of the fees.

Only three states returned the survey—Nebraska, Ohio, and Wisconsin—and these surveys were incomplete. However, through follow-up phone calls, some of the states provided B&A with additional information and all the states confirmed their fee schedules.

Findings

Overall Comparison to Medicare Rates

The Medicare program's Resource-Based Relative Value Scale (RBRVS) payment system allows for state-specific adjustments such as local wage costs and medical malpractice rates in the state. Therefore, there is not a national rate for each of the thousands of service codes that can be billed by physicians which make direct comparisons problematic. However, a global review of Medicare's payment rates to physicians versus what Minnesota's FFS program pays shows significant discrepancies.

Exhibit 1 shown on the next page illustrates the ratio of the weighted average Medicaid FFS rates to the Medicare rates for all physician services, primary care services only, and obstetric care services only. The data reflects rates tabulated from 2003 (the most recent compilation available) by the Kaiser Family Foundation[3]. The nine states that were surveyed to compare their Medicaid FFS rates to Minnesota's are shown in the Exhibit. The states are stratified among the four groups identified on the previous page: states selected by the HSMMD, high Medicaid states relative to Medicare (called "high Medicaid" going forward), low Medicaid states relative to Medicare (called "low Medicaid" going forward), and Vermont.

Minnesota's physician rates overall were paid at 79% of the Medicare rates in 2003, but primary care rates were paid at 64% of the Medicare rates and obstetric care rates were paid at 82% of the Medicare rates. Although the overall Medicaid-to-Medicare ratio places Minnesota above the national average when compared to other state Medicaid programs to Medicare's rates, the primary care and obstetric ratios are at the national average when compared to other states. Among the comparison states, Minnesota ranks in the middle for their Medicaid-to-Medicare ratio for primary care services and 7th lowest out of the ten for obstetric services.

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[2] 2007/08 AAP Medicaid Reimbursement Survey. American Academy of Pediatrics. Elk Grove Village, Illinois

[3] http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4

Despite these findings, this data is still not fully representative of the situation in 2009. This is because the Medicare RBRVS program applies inflationary adjustments to its rates each year whereas Minnesota has not provided any increase since 2003. Therefore, Minnesota's Medicaid-to-Medicare ratios are actually lower today than what is shown in Exhibit 1.

Exhibit 1
Medicaid Fee-for-Service Physician Rates as a Percentage of Medicare Rates, 2003

	Ratio of Medicaid to Medicare Rates		
	All Physician Services	Primary Care Only	Obstetric Care Only
United States	**69%**	**62%**	**84%**
Minnesota	**79%**	**64%**	**82%**
Michigan	62%	63%	60%
Oregon	86%	75%	117%
Washington	87%	79%	122%
Wisconsin	87%	73%	101%
Iowa	97%	94%	101%
Nebraska	95%	78%	94%
Indiana	68%	60%	77%
Ohio	68%	66%	79%
Vermont	83%	64%	114%

Source: www.statehealthfacts.org

Findings from Other States Related to Medication Management, Visit and Consultation Codes

For the comparison to other state Medicaid FFS programs, the three broad categories of services[4] that were studied include: Visit, Medication Management and Consultation; Pediatrics; and Selected Specialties. Three exhibits, beginning on page 8, display the data on a state-specific, rate-specific basis that is described below. Percentages above 100% indicate that the rate for the service in the particular state is greater than Minnesota's current rate; conversely, percentages below 100% indicate that the rate for the service is less than Minnesota's current rate.

The rows labeled "Average Percentage of MN" appear after groups of services. The lines are inserted as a summary point for relatively similar services, such as "Office/Outpatient visits" or "Inpatient hospital-related visits". The percentages presented on these lines are *simple averages* of the percentages presented for the various groups or sub-groups of services. The averages are not *weighted averages* that would allow the reader to reach conclusions about the absolute percentage differences in the fee schedules between states. The percentages on the "Average Percentage of MN" lines are intended to help the reader draw conclusions from the extensive amount of data shown.

From the data shown in Exhibit 2 displayed on page 8 for 29 specific services, it appears that:

[4] The specific services reviewed are organized by their Current Procedural Terminology and Healthcare Common Procedure Coding System (CPT/HCPCS) codes used by medical practitioners to bill for services.

- Minnesota's medication management rate is higher than any of the comparison states. The Minnesota rate is nearly twice the HSMMD-selected states' rates, between 20% and 30% higher than the high Medicaid states' rates, and between 38% and 47% higher than the low Medicaid states' rates.

- With respect to the Office/Outpatient visit average rates for both new and established patients, all the states have higher average rates than Minnesota. The HSMMD-selected states have average rates that are between 12% and 48% higher; the high Medicaid states have average rates that are between 47% and 74% higher; and the low Medicaid states are between 5% and 24% higher than Minnesota. This Office/Outpatient visit group of codes is the most frequently billed group of services by primary and specialist physicians.

- For the Emergency and Critical Care group of codes, seven of the comparison states have average rates equal to or higher than Minnesota. The largest difference is 66%, with most of other states trending toward rates that are 20% higher than Minnesota.

- Results are less consistent for most of the other services that were surveyed:

  - For the subgroup of Inpatient codes, only three comparison states have codes higher than Minnesota: one is a HSMMD selected state (Oregon) and the other two are the high Medicaid states. The states with higher rates are between 10% and 28% higher, whereas the states with the lower average rates are between 6% and 35% lower.

  - For the Inpatient Consultation groups of codes and the Office Consultation codes, it is a similar story to the Inpatient codes – four states are either equal to or higher than Minnesota, with Oregon again being the highest among the HSMMD selected states, and the two high Medicaid states being equal to or higher than Minnesota.

Findings from Other States Related to Pediatric Codes

Exhibit 3 on page 9 presents the rate information for 25 selected pediatric services where the majority of the rates are drawn from the American Academy of Pediatrics 2007/2008 study and they represent the most frequent codes billed by pediatricians.

From a pediatric service perspective, Exhibit 2 reveals that:

- All states are roughly equal with respect to the 90378 respiratory service code rate.

- All states have considerably higher (7% to 149%) average Office/Outpatient rates than Minnesota.

- For Inpatient visits, the average rate results are almost evenly split among the states: three states have higher rates (by as much as 30%) than Minnesota and five states have lower rates (by as much as 34%).

- For Office Consultations, the states are again about equally split for the average rates: four states are equal to or higher than Minnesota (by as much as 36%) and four states are lower (by as much as 31%).

- For Emergency pediatric services, virtually all of the comparison states have equal (one state) or higher (six states) rates, with Wisconsin recording the lowest rate at 62% of the Minnesota rate.

- Because Minnesota pays Pediatric Critical and Intensive care "by report" (meaning that it is paid as a function of each physician's billed charges), comparisons cannot be made to the other states.

- All states have considerably higher average rates than Minnesota for Preventive and Initial Pediatric care. The other states' average rates are at least 72% higher (for the low Medicaid states) and as much as 151% higher (for the high Medicaid states). The HSMMD selected states have average rates for these services that are between 83% and 177% higher than Minnesota's.

Findings from Other States Related to Selected Specialty Codes

Exhibits 4 and 5 on pages 10 and 11 present other states' rates as a percentage of Minnesota's rates for selected specialty codes. The exhibits include rates for high-volume services billed in Minnesota's FFS program by OB/GYNs (10 services shown), Psychiatrists (8 services shown), Neurologists (5 services shown), Orthopedic Surgeons (5 services shown), Cardiologists (9 services shown) and Dentists (11 services shown).

Exhibit 4 compares rates across the comparison states for OB/GYN and psychiatric services:

- For OB/GYN services, Minnesota has the lowest average rate of all the states except Indiana. The other states have average rates that range from 9% higher than Minnesota (Nebraska) to 50% higher (Oregon). The data indicates that the Minnesota rates are lower in virtually all of the Maternity codes but generally higher in the Exam codes.

- The rates for Psychiatric services have an interesting pattern. While five of the comparison states have average rates that are equal to or greater than Minnesota's, an examination of the specific services is revealing. All of the comparison states have significantly higher rates for Psychiatric Interviews and Group Psychotherapy (by margins of as much as 249%), but four of these states have lower Office treatment rates (Psychiatric treatment, office). Minnesota has the highest rates of the states with rates for short term residential day treatments.

Exhibit 5 compares rates across the comparison states for the other specialties:

- Minnesota's average rates for Neurology are the highest of all of the comparison states.

- Similarly, Minnesota's average rates (and most of the specific rates) in the Orthopedic Surgeon services group are higher than all of the comparison states.

- For Cardiologist services, three of the states have higher average rates than Minnesota but all states have higher rates for Doppler Color Flow and Left Heart Catheterization.

- Only three states have lower average dental rates than Minnesota—Michigan, Washington and Wisconsin.

Exhibit 2
Medication Management, Visit and Consultation Codes: Other States' FFS Rates as a Percentage of Minnesota's FFS Rates

		HSMMD Selected				High Medicaid		Low Medicaid		
CPT/HCPCS Code	Procedure Description	MI	OR	WA	WI	IA	NE	IN	OH	VT
90862	Medication Management	49%	64%	54%	53%	81%	68%	62%	53%	73%
99201	Office/Outpatient Visit, New Pat, 10 min	77%	98%	92%	81%	141%	114%	77%	80%	131%
99202	Office/Outpatient Visit, New Pat, 20 min	121%	153%	143%	121%	198%	149%	111%	118%	208%
99203	Office/Outpatient Visit, New Pat, 30 min	152%	190%	176%	153%	234%	185%	131%	148%	259%
99204	Office/Outpatient Visit, New Pat, 45 min	126%	171%	158%	128%	199%	155%	119%	132%	215%
99205	Office/Outpatient Visit, New Pat, 60 min	109%	146%	136%	111%	169%	137%	103%	113%	187%
99211	Office/outpatient visit, est. patient, 5 min	99%	120%	110%	99%	153%	135%	81%	109%	169%
99212	Office/outpatient visit, est. patient, 10 min	107%	133%	126%	107%	159%	139%	94%	120%	182%
99213	Office/outpatient visit, est. patient, 15 min	124%	181%	171%	123%	182%	174%	129%	163%	207%
99214	Office/outpatient visit, est. patient, 25 min	102%	147%	138%	103%	151%	140%	105%	133%	174%
99215	Office/outpatient visit, est. patient, 45 min	104%	139%	130%	106%	158%	141%	99%	126%	178%
	Average Percentage of MN	**112%**	**148%**	**138%**	**113%**	**174%**	**147%**	**105%**	**124%**	**191%**
99221	Initial hosp care, physician bedside 30 min	72%	121%	100%	112%	125%	85%	100%	70%	123%
99222	Initial hosp care, physician bedside 50 min	64%	91%	74%	67%	111%	80%	80%	55%	110%
99223	Initial hosp care, physician bedside 70 min	80%	119%	98%	68%	134%	93%	97%	69%	137%
99231	Subseq hosp care, physician bedside 15 min	64%	91%	75%	68%	115%	91%	83%	58%	110%
99232	Subseq hosp care, physician bedside 25 min	91%	141%	116%	74%	156%	127%	116%	81%	157%
99233	Subseq hosp care, physician bedside 35 min	49%	75%	62%	44%	82%	79%	62%	43%	84%
99238	Hospital discharge day mgmt, <= 30 min	98%	122%	100%	93%	157%	161%	108%	77%	169%
99239	Hospital discharge day mgmt, > 30 min	92%	121%	98%	131%	142%	184%	105%	70%	79%
	Average Percentage of MN	**76%**	**110%**	**90%**	**82%**	**128%**	**113%**	**94%**	**65%**	**121%**
99242	Office Consultation, 30 min	87%	111%	92%	96%	144%	104%	98%	65%	148%
99243	Office Consultation, 40 min	89%	117%	96%	101%	141%	102%	103%	68%	151%
99244	Office Consultation, 60 min	87%	119%	99%	87%	136%	90%	107%	69%	148%
99245	Office Consultation, 80 min	94%	124%	102%	74%	149%	103%	110%	72%	161%
	Average Percentage of MN	**89%**	**118%**	**97%**	**90%**	**143%**	**100%**	**104%**	**68%**	**152%**
99253	Initial Inpatient Consultation, 55 min	71%	106%	87%	101%	125%	107%	97%	63%	122%
99254	Initial Inpatient Consultation, 80 min	71%	106%	88%	78%	122%	97%	97%	61%	122%
99255	Initial Inpatient Consultation, 110 min	82%	110%	91%	73%	140%	109%	99%	68%	141%
	Average Percentage of MN	**75%**	**107%**	**88%**	**84%**	**129%**	**104%**	**98%**	**64%**	**128%**
99283	Emergency Dept. Visit, mid-level	94%	124%	100%	61%	164%	132%	117%	95%	160%
99284	Emergency Dept. Visit, mid-level	108%	167%	136%	53%	186%	115%	149%	116%	184%
99291	Critical Care, First 30-74 min	118%	157%	128%	72%	149%	125%	134%	80%	202%
	Average Percentage of MN	**107%**	**149%**	**121%**	**62%**	**166%**	**124%**	**133%**	**97%**	**182%**

Exhibit 3
Pediatric Codes: Other States' FFS Rates as a Percentage of Minnesota's FFS Rates

		HSMMD Selected				High Medicaid		Low Medicaid		
CPT/HCPCS Code	Procedure Description	MI	OR	WA	WI	IA	NE	IN	OH	VT
90378	Respiratory syncytial virus immune globulin, 50 mg	92%	100%	N/A	93%	86%	By Report	118%	97%	59%
99212	Office/outpatient visit, established patient, 10 min	107%	133%	222%	107%	159%	139%	94%	120%	182%
99213	Office/outpatient visit, established patient, 15 min	124%	181%	301%	123%	182%	174%	129%	163%	207%
99214	Office/outpatient visit, established patient, 25 min	102%	147%	243%	103%	151%	140%	105%	133%	174%
99215	Office/outpatient visit, established patient, 45 min	104%	139%	230%	106%	158%	141%	99%	126%	178%
	Average Percentage of MN	**109%**	**150%**	**249%**	**110%**	**162%**	**149%**	**107%**	**136%**	**185%**
99222	Initial hospital care, physician bedside 50 min	64%	91%	74%	67%	111%	80%	80%	55%	110%
99223	Initial hospital care, physician bedside 70 min	80%	119%	98%	68%	134%	93%	97%	69%	137%
99232	Subsequent hospital care, physician bedside 25 min	91%	141%	116%	74%	156%	127%	116%	81%	157%
99233	Subsequent hospital care, physician bedside 35 min	49%	75%	62%	44%	82%	79%	62%	43%	84%
99238	Hospital discharge day management, 30 min or less	98%	122%	100%	93%	157%	161%	108%	77%	169%
99239	Hospital discharge day management, more than 30 min	92%	121%	98%	131%	142%	184%	105%	70%	79%
	Average Percentage of MN	**79%**	**112%**	**92%**	**79%**	**130%**	**121%**	**95%**	**66%**	**123%**
99244	Office consultation, 60 minutes	87%	119%	99%	87%	136%	90%	107%	69%	148%
99283	Emergency dept visit, mid-level	94%	124%	100%	61%	164%	88%	117%	95%	160%
99284	Emergency dept visit, mid-level	108%	167%	136%	53%	186%	115%	149%	116%	184%
99291	Critical care, first 30-74 min	118%	157%	128%	72%	149%	125%	134%	80%	202%
99294	Pediatric critical care, per day, child 29 days-24 mo	**	**	**	**	**	**	**	N/A	**
99295	Pediatric critical care, per day, child < 29 days old	**	**	**	**	**	**	**	N/A	**
99296	Subsequent pediatric critical care, child < 29 days old	**	**	**	**	**	**	**	N/A	**
99298	Subsequent intensive care, body weight <1500g	**	**	**	**	**	**	**	N/A	**
99299	Subsequent intensive care, body weight 1500-2500g	**	**	**	**	**	**	**	N/A	**
99300	Subsequent intensive care, body weight 2501-5000g	**	**	**	**	**	**	**	N/A	**
	Average Percentage of MN	**107%**	**149%**	**121%**	**62%**	**166%**	**109%**	**133%**	**97%**	**182%**
99391	Preventive visit, age under one year	278%	215%	298%	225%	295%	299%	197%	186%	301%
99392	Preventive visit, age 1-4 years	307%	236%	336%	222%	321%	313%	216%	204%	332%
99394	Preventative Visit, Est, 12-17	301%	232%	350%	199%	325%	315%	214%	202%	326%
99431	Initial care, normal newborn	102%	85%	not available	218%	145%	211%	111%	N/A	119%
	Average Percentage of MN	**247%**	**183%**	**277%**	**185%**	**251%**	**250%**	**174%**	**172%**	**252%**

** Since Minnesota allows payment 'by report' for these codes, a percentage cannot be calculated; N/A means noncovered service by the state

Exhibit 4
OB/GYN and Psychiatric Codes: Other States' FFS Rates as a Percentage of Minnesota's FFS Rates

CPT/HCPCS Code	Procedure Description	HSMMD Selected				High Medicaid		Low Medicaid		
		MI	OR	WA	WI	IA	NE	IN	OH	VT
OB/GYN Services										
57454	Vagina Exam and Biopsy	75%	92%	74%	106%	80%	106%	58%	99%	101%
59409	Maternity Care and Delivery	147%	187%	192%	132%	170%	166%	140%	136%	198%
59410	Obstetrical Care	153%	201%	211%	134%	178%	188%	141%	148%	195%
59425	Maternity Care and Delivery	150%	239%	257%	152%	166%	29%	21%	N/A	19%
59426	Maternity Care and Delivery	138%	234%	252%	143%	156%	16%	12%	N/A	11%
76805	Echo Exam of Pregnant Uterus	86%	111%	96%	151%	139%	135%	106%	111%	127%
76811	Ob, us, detailed, sngl fetus	66%	78%	61%	98%	99%	94%	78%	80%	99%
76815	Echo Exam of Pregnant Uterus	91%	114%	96%	159%	146%	139%	111%	117%	131%
76817	Transvaginal us, obstetric	**	**	**	**	**	**	**	**	**
J7302	Levonorgestrel iu contracept	89%	89%	91%	84%	87%	N/a	105%	84%	84%
	Average Percentage of MN	**111%**	**150%**	**148%**	**129%**	**136%**	**109%**	**86%**	**111%**	**107%**
Psychiatric Services										
90801	Psychiatric Interview - 30 Min Unit	200%	313%	214%	345%	311%	291%	186%	212%	175%
90805	Psytx, office (20-30) w/e&m	67%	111%	70%	123%	109%	94%	83%	74%	92%
90806	Psytx, office (45-50)	74%	135%	74%	198%	122%	138%	84%	76%	78%
90807	Psytx, office (45-50) w/e&m	53%	90%	54%	132%	86%	94%	63%	56%	66%
90853	Group Psychotherapy	138%	349%	145%	284%	85%	297%	145%	146%	116%
90870	Electroconvulsive Therapy	56%	70%	58%	108%	62%	36%	47%	37%	21%
H0018	Behav Hlth; Short-term Resid., Day	77%	48%	58%	not available	not available	93%	0%	not available	69%
H2012	Behav Hlth Day Treatment, Per Hr	**	**	**	**	**	**	**	**	**
	Average Percentage of MN	**95%**	**159%**	**96%**	**198%**	**129%**	**149%**	**87%**	**100%**	**88%**

** Since Minnesota allows payment 'by report' for these codes, a percentage cannot be calculated; N/A means noncovered service by the state

Exhibit 5
Other Selected Specialty Codes: Other States' FFS Rates as a Percentage of Minnesota's FFS Rates

CPT/HCPCS Code	Procedure Description	HSMMD Selected				High Medicaid		Low Medicaid		
		MI	OR	WA	WI	IA	NE	IN	OH	VT
Neurology Services										
95816	Electroencephalogram (EEG) Awake/Drowsy	136%	136%	164%	135%	158%	98%	93%	108%	79%
95860	Muscle Test, One Limb	37%	18%	36%	52%	49%	45%	40%	34%	48%
95903	Motor Nerve Conduction Test	**	**	**	**	**	**	**	**	**
95904	Sense Nerve Conduction Test	82%	63%	78%	99%	77%	95%	63%	58%	76%
95951	EEG Monitoring/Video Record	133%	0%	By Report	79%	103%	66%	46%	49%	53%
	Average Percentage of MN	**97%**	**54%**	**92%**	**91%**	**96%**	**76%**	**61%**	**62%**	**64%**
Orthopedic Surgeon Services										
20610	Drain/Inject Joint/Bursa	95%	121%	101%	155%	165%	72%	84%	117%	47%
20680	Removal of Support Implant	96%	28%	116%	80%	91%	85%	66%	75%	47%
64721	Carpal Tunnel Surgery	39%	51%	41%	90%	60%	73%	44%	45%	46%
73221	Magnetic Image, Joint of Arm	43%	55%	48%	71%	70%	54%	49%	56%	68%
73721	Magnetic Image, Joint of Leg	43%	56%	49%	71%	70%	54%	49%	56%	84%
	Average Percentage of MN	**63%**	**62%**	**71%**	**93%**	**91%**	**68%**	**59%**	**70%**	**58%**
Cardiologist Services										
78465	Myocardial Perf Image, Tomograph, Mult	56%	68%	56%	94%	88%	73%	66%	70%	98%
92980	Insert Intracoronary Stent, Sing Vessel	54%	69%	57%	91%	113%	131%	98%	88%	97%
93010	Electrocardiogram Report	35%	44%	36%	60%	71%	144%	62%	56%	83%
93307	Echo Exam of Heart	67%	82%	66%	110%	113%	125%	88%	87%	92%
93320	Doppler Echo Exam, Heart	67%	82%	66%	110%	113%	135%	95%	87%	100%
93325	Doppler Color Flow	113%	115%	74%	183%	175%	187%	128%	132%	139%
93350	Echo Exam of Heart	28%	41%	39%	46%	37%	86%	61%	32%	55%
93510	Left Heart Catheterization	214%	258%	194%	350%	337%	325%	252%	254%	86%
93545	Injection for Coronary Xrays	4%	5%	25%	7%	12%	26%	25%	5%	11%
	Average Percentage of MN	**71%**	**85%**	**68%**	**117%**	**117%**	**137%**	**97%**	**90%**	**85%**
Dental Services										
D0120	Periodic Oral Evaluation	80%	129%	118%	70%	89%	86%	121%	91%	96%
D0150	Comprehensive Oral Evaluation	58%	147%	106%	78%	94%	63%	139%	103%	2290%
D0330	Panoramic Film	38%	50%	58%	81%	100%	73%	138%	99%	103%
D1110	Adult Prophylaxis	83%	143%	141%	102%	137%	117%	180%	129%	147%
D2150	Amalgam - Two Surfaces	75%	114%	116%	102%	142%	151%	195%	130%	175%
D2391	Post 1 Srfc Resin Based Cmpst	31%	75%	72%	82%	105%	125%	110%	102%	179%
D2392	Post 2 Srfc Resin Based Cmpst	50%	76%	78%	86%	119%	129%	104%	87%	215%
D4341	Peridont Scaling/Root Planning Per Quad	not available	75%	31%	89%	121%	116%	180%	N/A	98%
D5110	Complete Upper	72%	76%	97%	92%	114%	120%	92%	84%	128%
D5214	Mandibular Partial Denture	68%	65%	99%	68%	108%	90%	142%	97%	115%
D7140	Extraction Erupted Tooth/ext	57%	174%	74%	89%	116%	116%	173%	117%	1306%
	Average Percentage of MN	**61%**	**102%**	**90%**	**85%**	**113%**	**108%**	**143%**	**104%**	**441%**

** Since Minnesota allows payment 'by report' for these codes, a percentage cannot be calculated; N/A means noncovered service by the state

SECTION III: SUMMARY OF THE REPORT COMPARING PAYMENT RATES FOR SERVICES DELIVERED BY PHYSICIANS AND NON-PHYSICIANS TO MEDICAID FEE-FOR-SERVICE BENEFICIARIES

Appendix B offers detailed analyses of how services provided by both physicians and non-physicians to Medicaid fee-for-service (FFS) beneficiaries were identified and how the rates differ across provider types. The average rate paid to physicians and nonphysicians is compared for 21 service codes. In summary, the volume of services and amount of payments made is low for services when both a physician and nonphysician bill for the same service. When it does occur, it is not because Minnesota's DHS has published a rate to pay the nonphysician at a higher rate. Rather, the higher rate is an artifact of special pricing considerations. These payment adjustments, developed over time as a result of various legislative requirements, yield little transparency to providers with regard to what they will actually be paid. For example,

- Pediatric services are paid a 15% upward adjustment from the base rate
- Obstetric providers receive a 26.5% upward adjustment from the base rate
- Community and public health clinics receive a 20% upward adjustment from the base rate
- Advance practice nurses receive a 10% reduction from the physician's rate
- Physicians receive a 40% downward adjustment from the base rate when the service is delivered in an outpatient hospital setting instead of in a doctor's office

Methodology

Among the 8,270 service codes billed by physicians during the study period July 1, 2006 – June 30, 2008, 91 percent of them (7,520) were billed less than 500 times by physicians. These were removed from our analysis. The remaining 750 services were further examined to study if other provider types in addition to physicians billed these services. In order for a service code to be included in the analysis, all of the following criteria must be met:

- Physicians could not represent less than 50 percent of the total payments made for the service.
- Physicians could not represent more than 90 percent of the total payments made for the service.
- A specific nonphysician provider must represent at least 10 percent of the total payments made for the service.
- Both physician and nonphysician payments for the service code must equal at least $50,000 over the two-year period of claims studied.

Additionally, Minnesota's DHS, like Medicaid agencies nationwide, are constrained in the fees they can pay providers for laboratory services to the maximum rate on the Medicare Clinical Laboratory fee schedule. Because Minnesota's rates for lab services are the same across provider types, these services were removed from the analysis. This was also true for three drug codes commonly billed by physicians and nonphysicians.

Utilizing the criteria above, a net result of 21 service codes remained for analysis.

Findings

Payment rates for services delivered by physicians and the specific nursing provider types are detailed in Exhibits 6 and 7 on pages 14 and 15. Exhibit 6 compares rates paid to physicians and nurse practitioners for office/outpatient evaluation and visits. Exhibit 7 compares physicians to nurse practitioners, clinical nurse specialists and nurse midwives for services other than office/outpatient evaluation related to physical health.

There are some meaningful differences in the average rates paid between physicians and nonphysicians for the 21 services examined. This, however, should be reviewed in the context of all payments made to these providers. For example, in our two-year dataset, these 21 codes examined represent 21 percent of the $301 million in payments made to physicians. Among nonphysicians, the total payments made were $7.5 million. Among the 21 services studied, 82 percent of the payments were made to physicians and only 18 percent to nonphysicians. Finally, among nonphysicians, 89 percent of the payments are concentrated in only 10 services. Each of these will be discussed below.

Five of the high-volume services paid to nonphysicians are for office/outpatient evaluations or visits for new or established patients (refer to the first five codes listed on Exhibit 1). For the new patient codes (CPT 99202 and 99205), nurse practitioners were paid, on average, six percent higher than physicians. For the established patient codes, nurse practitioners were paid 11 percent higher for a 10 minute visit (CPT 99212), 73 percent higher for a 15 minute visit (CPT 99213), and the same amount for a 40 minute visit (CPT 99215) when these visits are in an office setting. When the visits are in an outpatient hospital setting, the average payment to nurse practitioners is higher than physicians because of the special pricing rule that physician rates are discounted 40 percent from the published rate when the service is performed in an outpatient setting.

The other five high-volume services appear on Exhibit 2. When comparing average rates paid to physicians and clinical nurse specialists delivering the same service, the clinical nurse specialist is paid on average either two percent lower or 23 percent lower than physicians for a 20-30 minute psychotherapy session, depending upon the setting (CPT 90805). For a 45-50 minute session, the nurse is paid on average 12 percent less than the physician (CPT 90807). For pharmacological management (CPT 90862), the rate paid to the nurse may be greater or higher than the physician based upon the setting. It was found that in the office setting, the nurse was paid 20 percent less than the physician; in the outpatient hospital setting, 71 percent higher than the physician; and in other settings, about the same as the physician.

The other two high-volume services are for routine obstetrical care (CPT 59400) and vaginal delivery, including postpartum care (CPT 59410). The average rates are compared between the physicians and nurse midwives. In the case of CPT 59400, the nurse midwife on average was paid five percent more than the physician; for CPT 59410, the nurse midwife was paid three percent more than the physician.

Exhibit 6
Comparison of FFS Services Billed by Physicians and Nurse Practitioners, SFYs 2007 and 2008

CPT Code	CPT Description	Dollars Paid Out for Service	Percent Paid to Physicians	Percent Paid to Nurse Practitioners	Avg Rate Paid to Physicians	Avg Rate Paid to Nurse Practitioners	Percent Nurse Avg Rate is Higher/Lower than Physician Avg Rate
99202	Office/outpatient visit, new patient, 20 min						
	Office Setting	$785,951	81%	19%	$31.29	$33.16	6%
99205	Office/outpatient visit, new patient, 60 min						
	Office Setting	$609,205	68%	32%	$97.29	$103.56	6%
99212	Office/outpatient visit, established patient, 10 min						
	Office Setting	$2,294,468	84%	16%	$27.63	$30.57	11%
	Outpatient Hospital Setting	$1,999,858	86%	14%	$78.42	$94.45	20%
99213	Office/outpatient visit, established patient, 15 min						
	Office Setting	$10,829,181	82%	18%	$27.23	$47.11	73%
	Outpatient Hospital Setting	$6,128,523	80%	20%	$66.39	$103.08	55%
99215	Office/outpatient visit, established patient, 40 min						
	Office Setting	$2,334,264	89%	11%	$65.88	$65.66	0%
	Outpatient Hospital Setting	$585,780	83%	17%	$45.71	$52.44	15%
99308	Subsequent nursing facility care, 15 min with patient						
	Non-office or Hospital Setting	$161,143	54%	46%	$36.07	$36.10	0%
99384	Initial comprehensive preventive medicine evaluation and management, age 12-17						
	Office Setting	$118,755	54%	46%	$29.09	$35.49	22%
99392	Periodic preventive medicine reevaluation, age 1-4						
	Office Setting	$365,419	78%	22%	$16.28	$36.21	122%
	Outpatient Hospital Setting	$171,620	84%	16%	$48.09	$38.92	-19%
99394	Periodic preventive medicine reevaluation, age 12-17						
	Office Setting	$224,865	64%	36%	$20.45	$37.06	81%
99396	Periodic preventive medicine reevaluation, age 40-64						
	Office Setting	$315,618	87%	13%	$33.67	$37.52	11%

Exhibit 7
Comparison of FFS Services Billed by Physicians and Other Nursing Provider Types, SFYs 2007 and 2008

CPT Code	CPT Description	Dollars Paid Out for Service	Percent Paid to Physicians	Percent Paid to Nurse Practitioners	Avg Rate Paid to Physicians	Avg Rate Paid to Nurse Provider	Percent Nurse Avg Rate is Higher/Lower than Physician Avg Rate
Comparing Physician Rates to Nurse Practitioner Rates (non office/outpatient evaluation or visit)							
90471	Immunization administration, single or combination vaccine						
	Office Setting	$435,396	86%	14%	$5.01	$6.26	25%
90472	Immunization administration, each additional vaccine						
	Office Setting	$305,502	82%	18%	$8.79	$11.62	32%
90649	HPV vaccine						
	Office Setting	$249,740	80%	20%	$34.92	$35.15	1%
99436	Attendance at delivery						
	Inpatient Hospital Setting	$135,542	54%	46%	$71.93	$69.72	-3%
Comparing Physician Rates to Clinical Nurse Specialist Rates							
90805	Individual psychotherapy, 20-30 min, with medical evaluation and management						
	Office Setting	$1,190,674	92%	8%	$62.84	$48.67	-23%
	Non-office or Hospital Setting	$268,612	58%	42%	$64.25	$62.70	-2%
90807	Individual psychotherapy, 45-50 min, with medical evaluation and management						
	Office Setting	$381,472	75%	25%	$113.37	$100.14	-12%
90862	Pharmacologic management						
	Office Setting	$3,412,357	86%	14%	$67.32	$53.61	-20%
	Outpatient Hospital Setting	$780,686	82%	18%	$46.94	$80.34	71%
	Any Other Setting	$2,229,339	67%	33%	$63.69	$65.05	2%
Comparing Physician Rates to Nurse Midwife Rates							
59400	Routine obstetrical care						
	Any Setting	$2,692,245	88%	12%	$776.41	$813.91	5%
59409	Vaginal delivery only						
	Inpatient Hospital Setting	$802,675	89%	11%	$514.08	$459.15	-11%
59410	Vaginal delivery, including postpartum care						
	Inpatient Hospital Setting	$1,270,759	88%	12%	$566.65	$584.78	3%
H1001	Prenatal care; at-risk enhanced service; antepartum management						
	Office Setting	$211,218	91%	9%	$79.81	$79.93	0%
	Outpatient Hospital Setting	$57,377	38%	62%	$82.92	$83.50	1%

SECTION IV: SUMMARY OF THE REPORT RELATED TO THE AVAILABILITY OF PHYSICIAN SERVICES TO MEDICAID FEE-FOR-SERVICE BENEFICIARIES

Appendix C provides B&A's full analysis on the availability of Medicaid fee-for-service (FFS) primary care services and selected specialty services. Availability of services is examined at the statewide level, regional level and county level. FFS beneficiaries' utilization of services from each provider type were studied during State Fiscal Years 2007 and 2008 to determine if the level of a member's availability of care ultimately has an impact on the services they receive. This section summarizes the methodology used to complete this analysis and findings from the report.

Methodology

In order to map recipients and providers by geographic area, it is necessary to first define the population that is considered in this analysis. Enrollment information was obtained from the HSMMD for the State Fiscal Years (SFY) 2007 and 2008 (July 1, 2006 – June 30, 2008). B&A limited the recipients to include only those who had been enrolled for at least three consecutive months in the FFS program. Recipients were mapped by residence as of December 2008. Further limiting the group to in-state recipients, this report includes 473,276 members (or 56% of all FFS members during the period).

Among a total of 110,430 Minnesota providers that serve FFS enrollees, B&A focused on primary care providers and select physician specialties. Providers were assigned to a specialty group using the specialty codes and provider type used by the HSMMD. The same logic used to categorize providers into mutually exclusive groups was the same in all of the reports we delivered. Primary care providers consist primarily of physicians, but also some non-physicians that provide primary care services (most of whom are nurse practitioners). After excluding out-of-state providers, a total of 14,121 providers were considered in this analysis which was comprised of the following specialties: primary care providers (8,967), OB/GYNs (801), psychiatrists (704), dentists (2,018), cardiologists (476), neurologists (526), and orthopedic surgeons (629).

Primary Care Providers are the focus for most of this analysis and are stratified based on the number of monthly claims they submitted. B&A calculated the number of months that each provider was enrolled in the FFS program and the number of claims each provider billed to Medicaid FFS during SFY 2007 and SFY 2008. Dividing total claims billed by total months enrolled, the average number of claims per month was determined. Providers were then categorized into one of three groups based on their average. The definitions and number of in-state Primary Care providers corresponding with each group is as follows:

Active Primary Providers	More than 3 claims billed on average per month	4,899
Limited Primary Providers	Between 1 and 3 claims billed on average per month	1,469
Inactive Primary Providers	No more than 1 claim billed on average per month	2,599
		8,967

Services were also tied to each of the members for the two-year period studied. Analyses measuring the utilization per 1,000 FFS members for each provider type within a specific region of the state were completed. It should be noted that although results are shown for utilization of services per 1,000 FFS members in the county, we included services delivered to members from providers outside of the county in which they live or even from border states.

Services delivered for primary care services were further segmented into four categories for additional analysis. This was determined by the presence of procedure (CPT) codes on the claims billed by providers. Four categories were defined and are hierarchical in nature so that claims were categorized only once if criteria were met for more than one category. The categories and how they were defined are as follows:

1. Services performed by the provider in an office setting. This includes visits for new and established patients as well as consultations and medication management. [CPT codes 99201-99215, 99241-99245 and 90862]

2. Evaluation and management of a patient in the hospital setting (other than emergency room). This includes observation care. [CPT codes 99217-99239 and 99251-99255]

3. Evaluation and management of a patient in the emergency room. [CPT codes 99281-99288]

4. All other services except laboratory, medical supplies and pharmacy. This includes services that may be administered by a provider in the office or as a professional service completed in a hospital setting other than those stated above. If a provider billed for only a lab test, a medical supply (HCPCS codes), or a drug (J-codes) on a claim, the claim was excluded from our analysis.

Findings

Statewide Results for Primary Care

The 8,967 in-state Primary Care providers in this study were categorized as Active, Limited or Inactive based upon the number of services (claims) they billed the state for FFS members during SFYs 2007 and 2008. Since physicians who participate in the State's employee benefit program must also agree to participate in the Medicaid FFS program, distinctions can be made between those who actively seek Medicaid FFS members as patients and those who see members more on an ad hoc basis. The designation of Active, Limited and Inactive was created to measure the potential availability that members may have in their region against the more realistic measure of availability of actively-participating providers.

All of the primary care providers designated as Active, Limited or Inactive in the study had at least some experience with the FFS program in the last two years. There are other primary care providers who do not serve FFS members but do participate in the Medicaid managed care program. It is important to recognize these providers as another potential source that FFS members may have in their region if the managed care providers agreed to participate in the FFS program.

Exhibits 8, 9 and 10 shown on the following pages measure the level of availability of primary care that FFS members have in their county under three scenarios. Each county is assigned a designation of "low availability", "medium availability", "high availability" or "no availability" (no providers) by calculating the number of FFS members in the county by the number of providers in the county.[5] The number of primary care providers used in the calculation differs in each exhibit, while the number of members remains constant.

[5] Services provided by Indian Health Facilities were excluded from the analysis. Although this affects most counties in Minnesota to some degree, it means that findings cannot be concluded for Red Lake County in particular.

- Exhibit 8 includes only the Active FFS primary care providers in the calculation.

- Exhibit 9 includes All FFS primary care providers (Active, Limited and Inactive) in the calculation.

- Exhibit 10 includes all the FFS primary care providers as well as all of the Medicaid managed care primary care providers in the calculation.

Exhibit 8, which appears on page 19, shows that there is sufficient availability in all of the larger cities in the state when only Active FFS providers are considered, but there is no availability in five counties and low availability in ten other rural counties. If all FFS providers are considered (Exhibit 9 on page 20), the number of low availability counties is reduced to two (Benton and Dodge). There is no improvement for these counties if primary care providers in the managed care program are also considered (Exhibit 10 on page 21). However, including the managed care providers improves availability overall. The number of counties with high availability increase from 27 to 57 when changing from Active-only FFS providers to All FFS providers. When managed care providers are included, the number of high availability counties increase to 65.

The designation of low, medium or high provider availability within a specific county in and of itself cannot determine if there is a potential access issue. FFS beneficiaries may utilize the service of primary care physicians in counties outside of the one where they live, particularly if they live near a county border. Additional analyses of primary utilization were conducted, therefore, to determine if there is a relationship between low availability and low access. This analysis is shown on page 23.

Exhibit 8
Fee-for-Service Members per Active FFS Primary Care Provider, By County, SFYs 2007-2008

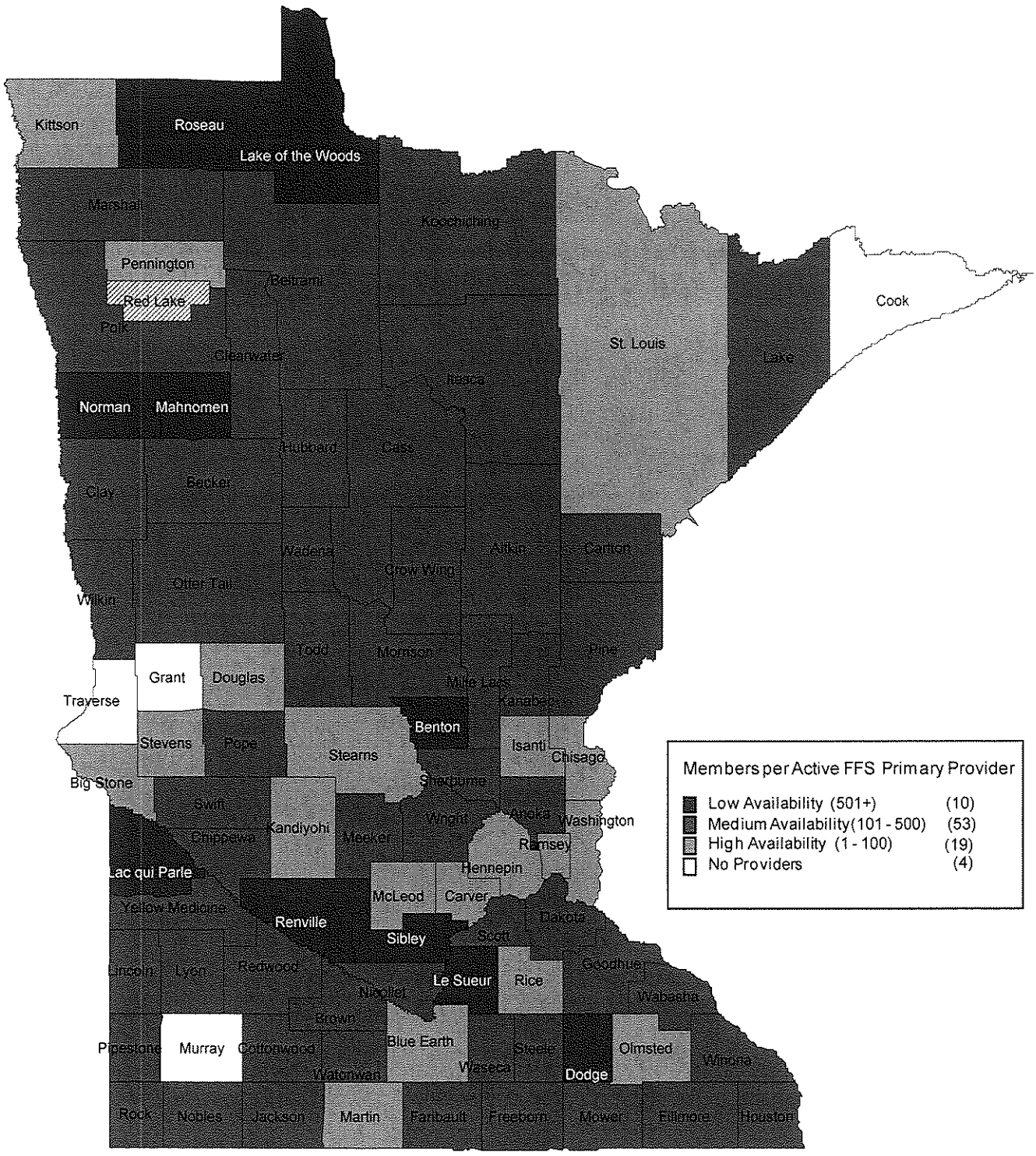


Exhibit 9
Fee-for-Service Members per All FFS Primary Care Providers, By County, SFYs 2007-2008

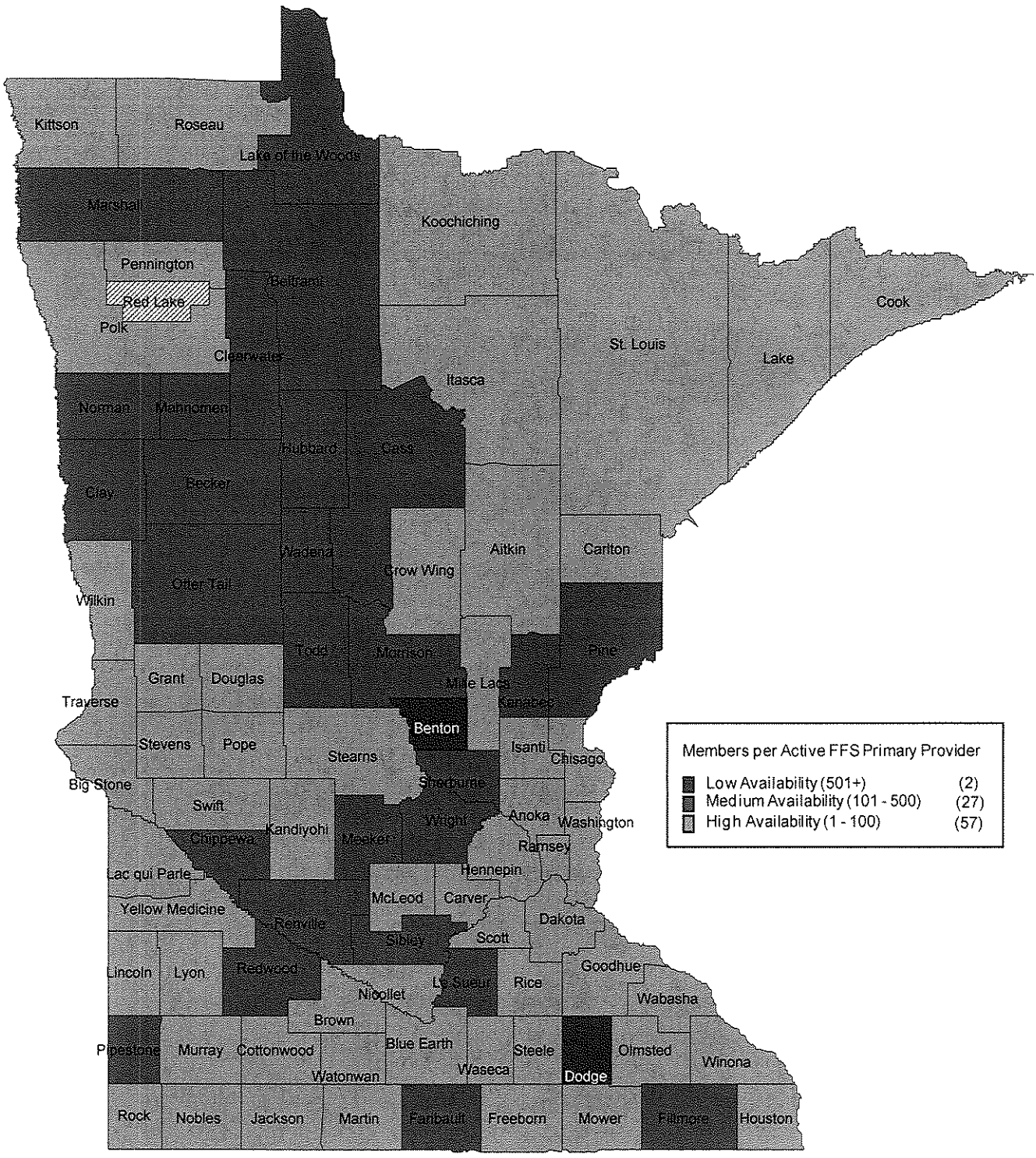
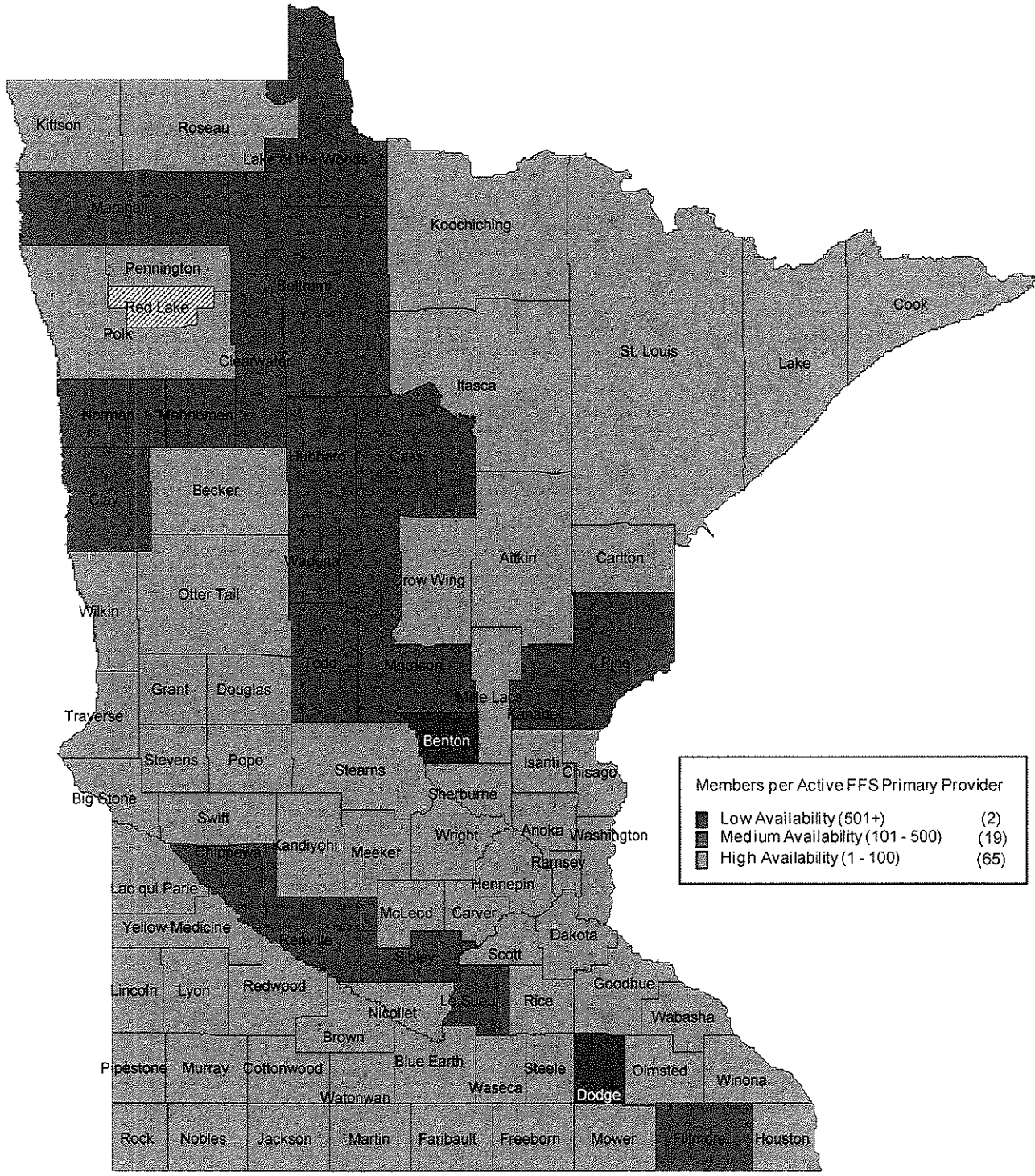


Exhibit 10
Fee-for-Service Members per All FFS and Managed Care Primary Care Providers, By County, SFYs 2007-2008



Region Level Results for Primary Care

The majority of FFS primary care providers (55%) in Minnesota are active providers, that is, they had more than three claims per month in SFY 2007 and SFY 2008. The only region without a majority of primary care providers categorized as active was the Southeast Region. As the Mayo Clinic is located in the Southeast Region of the state, this region has about one-fifth of the state's primary providers in it; however, 74% of these providers are limited or inactive.

Exhibit 11
Medicaid FFS Primary Care Provider Base by Region, SFYs 2007-2008

	Active		Limited		Inactive		Total
	N	%	N	%	N	%	N
Statewide		55%		16%		29%	
Northwest Providers	168	67%	23	9%	60	24%	251
Northeast Providers	416	66%	77	12%	141	22%	634
West Central Providers	107	63%	29	15%	35	23%	171
Central Providers	491	70%	83	12%	131	19%	705
Metro Providers	2,896	60%	758	16%	1,175	24%	4,829
Southwest Providers	156	58%	37	14%	74	28%	267
South Central Providers	214	60%	44	12%	99	28%	357
Southeast Providers	451	26%	422	24%	880	50%	1,753

Exhibit 12 below considers not only FFS primary care providers, but also managed care providers and calculates the percent of active FFS primary care providers of all providers (FFS providers and managed care providers). Although some regions have a low number of FFS providers, availability increases if managed care providers could also serve this population. While the Central, Northwest and Northeast regions have the highest number of active providers per FFS primary care providers, they also have the highest number of active providers per all primary care providers. In most regions, the number of managed care providers is similar to the number of inactive FFS providers.

Exhibit 12
Summary of Potential Primary Care Provider Availability for Medicaid FFS Beneficiaries By Region, SFYs 2007-2008

	FFS Providers			Managed Care Providers	Total Primary Care Providers	Percent Active FFS Primary Care Providers
	Active	Limited	Inactive			
Northwest Providers	168	23	60	44	295	57%
Northeast Providers	416	77	141	137	771	54%
West Central Providers	107	25	39	38	209	51%
Central Providers	491	83	131	127	832	59%
Metro Providers	2,896	758	1,175	1,191	6,020	48%
Southwest Providers	156	37	74	65	332	47%
South Central Providers	214	44	99	91	448	48%
Southeast Providers	451	422	880	466	2,219	20%

Exhibit 13 is intended to measure if low *availability* of FFS providers results in low *usage* of primary care services or of higher ER usage. This could indicate if there are potential access issues. Office visits and ER visits are shown on a per 1,000 FFS member basis so that results can be compared across regions with different levels of Medicaid participation. The per 1,000 ratios reflect utilization in the two-year period of SFYs 2007-2008.

FFS members in the Northwest Region are the biggest users of primary care services and ER services (measured on a per 1,000 member basis). But this region also has a relatively high availability of active primary care providers. Utilization of office visits in the Central, South Central, Southeast and Southwest Regions were below the state average. Of these regions, only the Southeast Region also has a high utilization of ER visits per 1,000 FFS members.

Exhibit 13
Primary Care Utilization for Medicaid FFS Members by Region, SFYs 2007-2008

	Services Delivered by Primary Care Provider Based on Setting				
	Office Visits	**ER Visits**	**Other Hospital Visits**	**Office Visits per 1,000 FFS Enrollees**	**ER Visits per 1,000 FFS Enrollees**
Statewide	70%	11%	18%	1,600	255
Northwest Providers	75%	15%	10%	2,416	488
Northeast Providers	72%	14%	14%	1,962	365
West Central Providers	73%	13%	14%	1,639	299
Central Providers	69%	14%	17%	1,325	255
Metro Providers	70%	9%	21%	1,577	204
Southwest Providers	74%	9%	18%	1,394	177
South Central Providers	76%	10%	14%	1,360	184
Southeast Providers	69%	17%	14%	1,393	328

When specific counties with low or no availability of primary care providers in the county for Medicaid FFS members are considered, there is not always a direct correlation showing that low availability equals low access. Exhibit 14 on the next page reviews the counties that were designated either 'Low Availability' or 'No Availability' when actively-participating FFS primary care providers were identified. In many of these counties, office visits per 1,000 FFS members were lower than the statewide average, but not all. One might expect in this case that ER visits per 1,000 would be higher if there was truly an issue related to access to primary care, but this was not found to be true. In fact, among the 15 counties identified as low or no availability to primary care, only one county had higher ER usage than the statewide average (Mahnomen), but it also had higher primary office visits per 1,000 members as well. Most of these counties had ER usage much lower than the statewide average, implying that access to primary care does not appear to be an issue.

Exhibit 14
FFS Office Visit and ER Utilization in Counties with Low or No Primary Care Provider Availability
SFYs 2007-2008

	Low or No Availability Designation	Office Visits per 1,000 FFS Enrollees	ER Visits per 1,000 FFS Enrollees
		Compared to Statewide Average	
Benton	Low	Similar	Much lower
Cook	No	Much lower	Much lower
Dodge	Low	Lower	Lower
Grant	No	Lower	Similar
Lac qui Parle	Low	Much lower	Much lower
Lake of the Woods	Low	Much lower	Much lower
Le Sueur	Low	Lower	Similar
Mahnomen	Low	Much higher	Higher
Murray	No	Lower	Much lower
Norman	Low	Much lower	Much lower
Red Lake	No	Higher	Much lower
Renville	Low	Lower	Much lower
Roseau	Low	Much lower	Much lower
Sibley	Low	Much lower	Much lower
Traverse	No	Lower	Similar

Statewide Results for Selected Specialists

B&A selected six specialist providers that are highly utilized by Medicaid FFS populations nationally to measure the availability of care that Minnesota's FFS enrollees have to these specialties. Each specialist is displayed in a statewide map on the following pages to determine the level of availability of specialists. The specialties include:

- Exhibit 17: OB/GYNs (female FFS members only are measured for availability)
- Exhibit 18: Psychiatrists
- Exhibit 19: Dentists
- Exhibit 20: Cardiologists
- Exhibit 21: Neurologists
- Exhibit 22: Orthopedic Surgeons

From an urban/rural perspective, in general there is sufficient availability of each specialist type in the urban areas of the state and a limited number of specialists in the rural regions. The one exception is for dentists where availability is spread evenly among most counties and only three counties do not have dentists available to FFS members.

B&A examined the cities with populations greater than 60,000 citizens based on the latest census data available. The table below is a summary of the findings shown in Exhibits 17 through 22 for the urban regions in the state.

Exhibit 15
Level of FFS Availability for Selected Specialties in Urban Areas of the State, SFYs 2007-2008
High Availability = 1-200 Medicaid FFS members per specialist
Medium Availability = 201-1,000 Medicaid FFS members per specialist
Low Availability = 1000 or more Medicaid FFS members per specialist

City/Cities	County	OB/GYN	Psych.	Dentist	Cardiology	Neurology	Ortho
Duluth	St. Louis	Medium	Medium	Medium	High	High	High
St. Cloud	Stearns	Medium	Medium	Medium	High	High	High
Rochester	Olmstead	High	High	Medium	High	High	High
Coon Rapids	Anoka	Medium	Medium	Medium	Medium	Medium	Medium
Twin Cities*	Hennepin, Ramsey, Dakota	Medium	Medium	Medium	Medium to High	Medium to High	Medium to High

*Includes Bloomington, Brooklyn Park, Burnsville, Minneapolis, Eagan, Plymouth, St. Paul

Conversely, availability of care is low to nonexistent in rural areas of the state (table below excludes the seven counties listed above).

Exhibit 16
Level of FFS Availability for Selected Specialties in Rural Areas of the State, SFYs 2007-2008

Specialist Type	Counties with Availability	Counties with Low Availability	Counties with No Availability
OB/GYN	34	6	40
Psychiatrist	18	20	42
Dentist	67	10	3
Cardiologist	4	1	75
Neurologist	4	9	67
Orthopedic Surgeon	29	6	45

The impact of provider availability and potential access concerns is explored beginning on page 32.

Exhibit 17
Female Fee-for-Service Members per OB/GYN, By County, SFYs 2007-2008

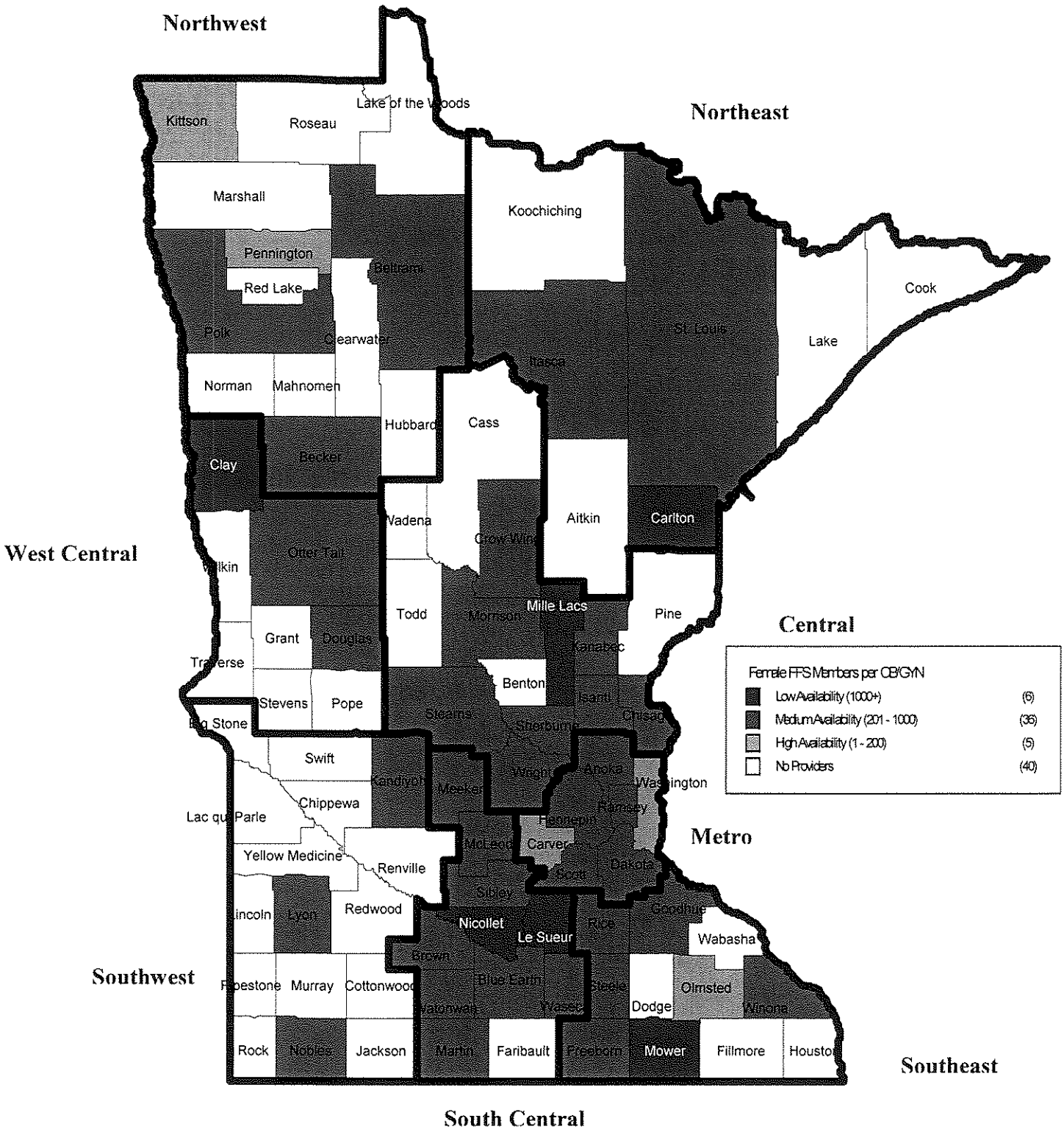


Exhibit 18
Fee-for-Service Members per Psychiatrist, By County, SFYs 2007-2008

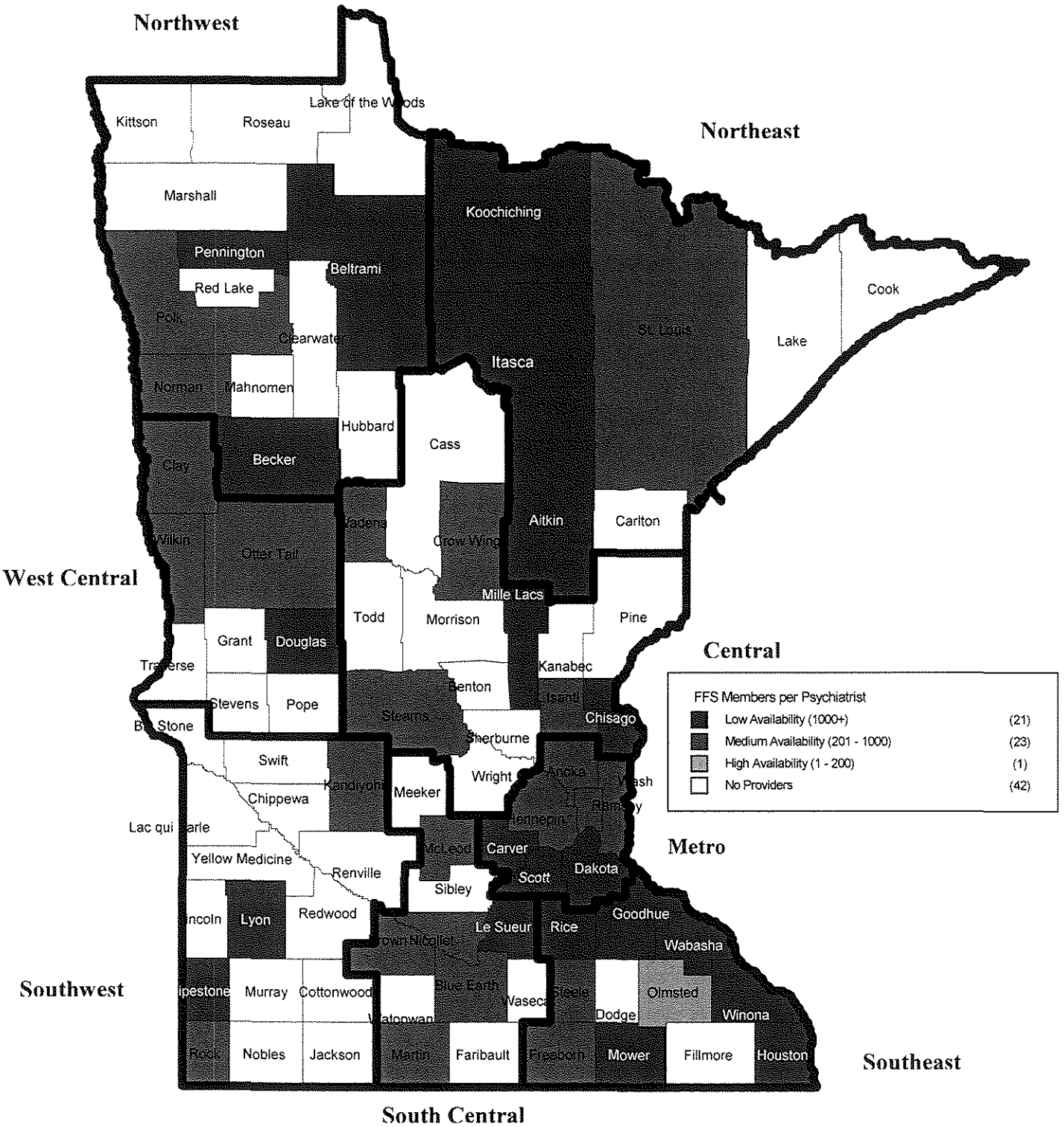


Exhibit 19
Fee-for-Service Members per Dentist, By County, SFYs 2007-2008

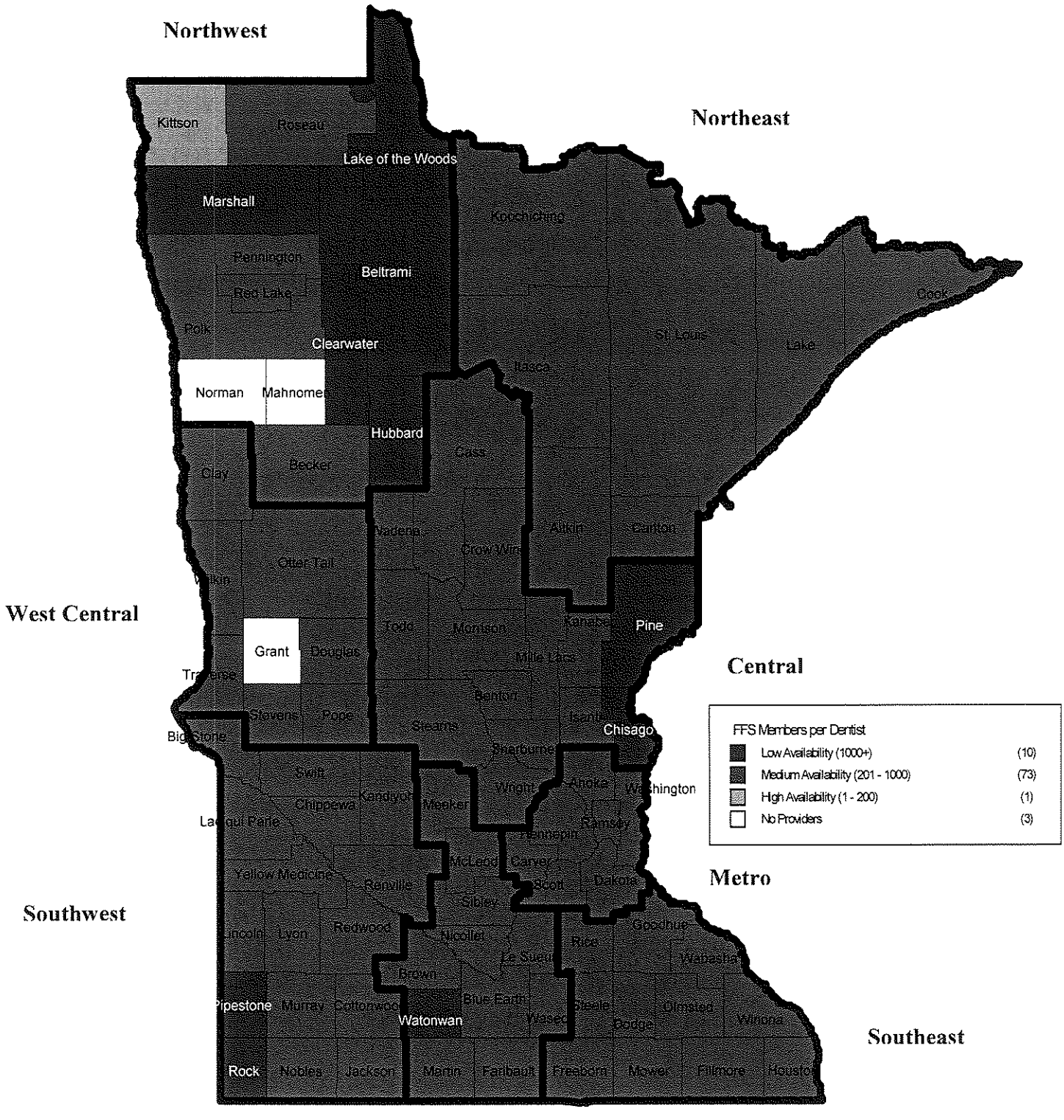


Exhibit 20
Fee-for-Service Members per Cardiologist, By County, SFYs 2007-2008

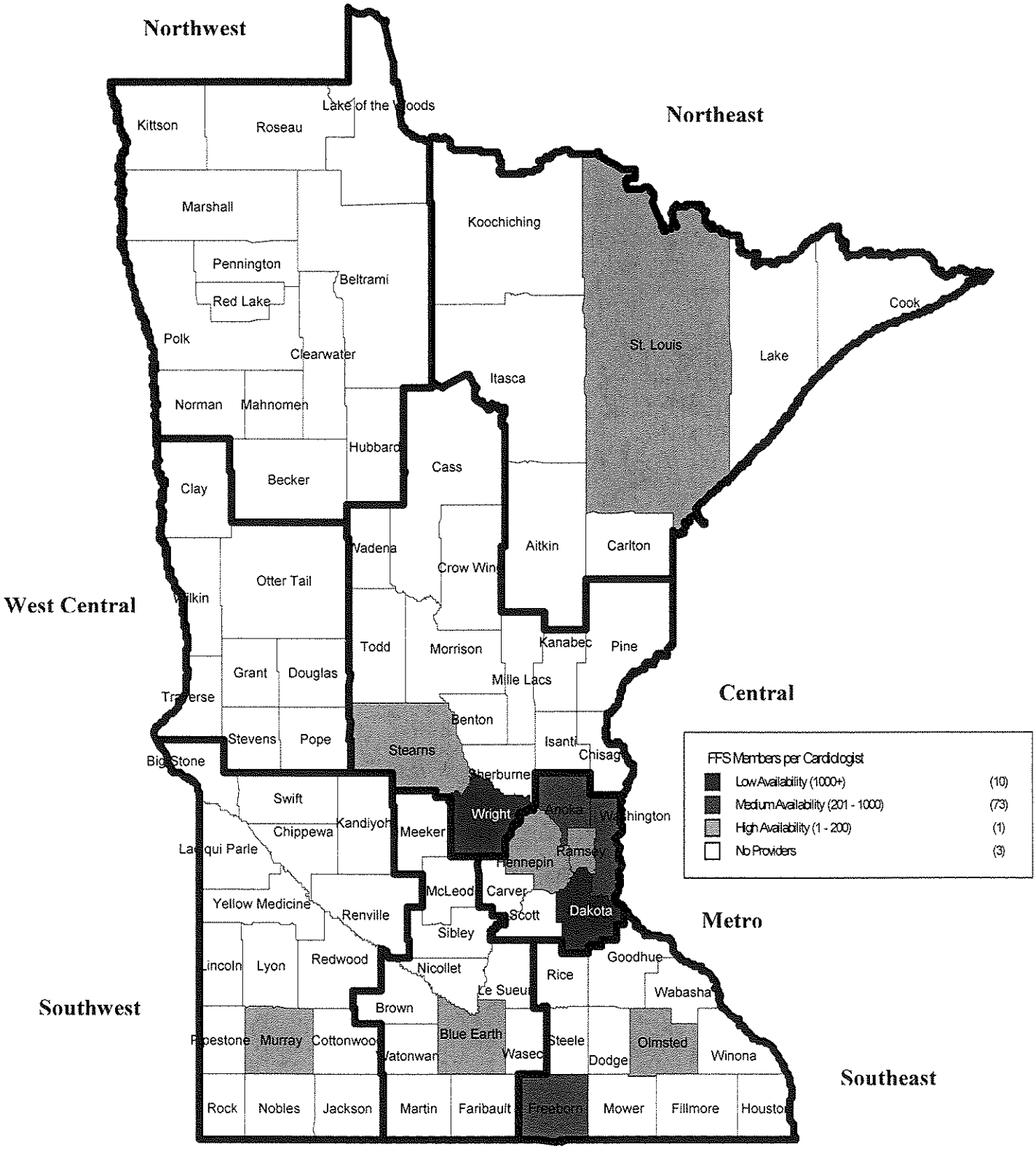


Exhibit 21
Fee-for-Service Members per Neurologist, By County, SFYs 2007-2008

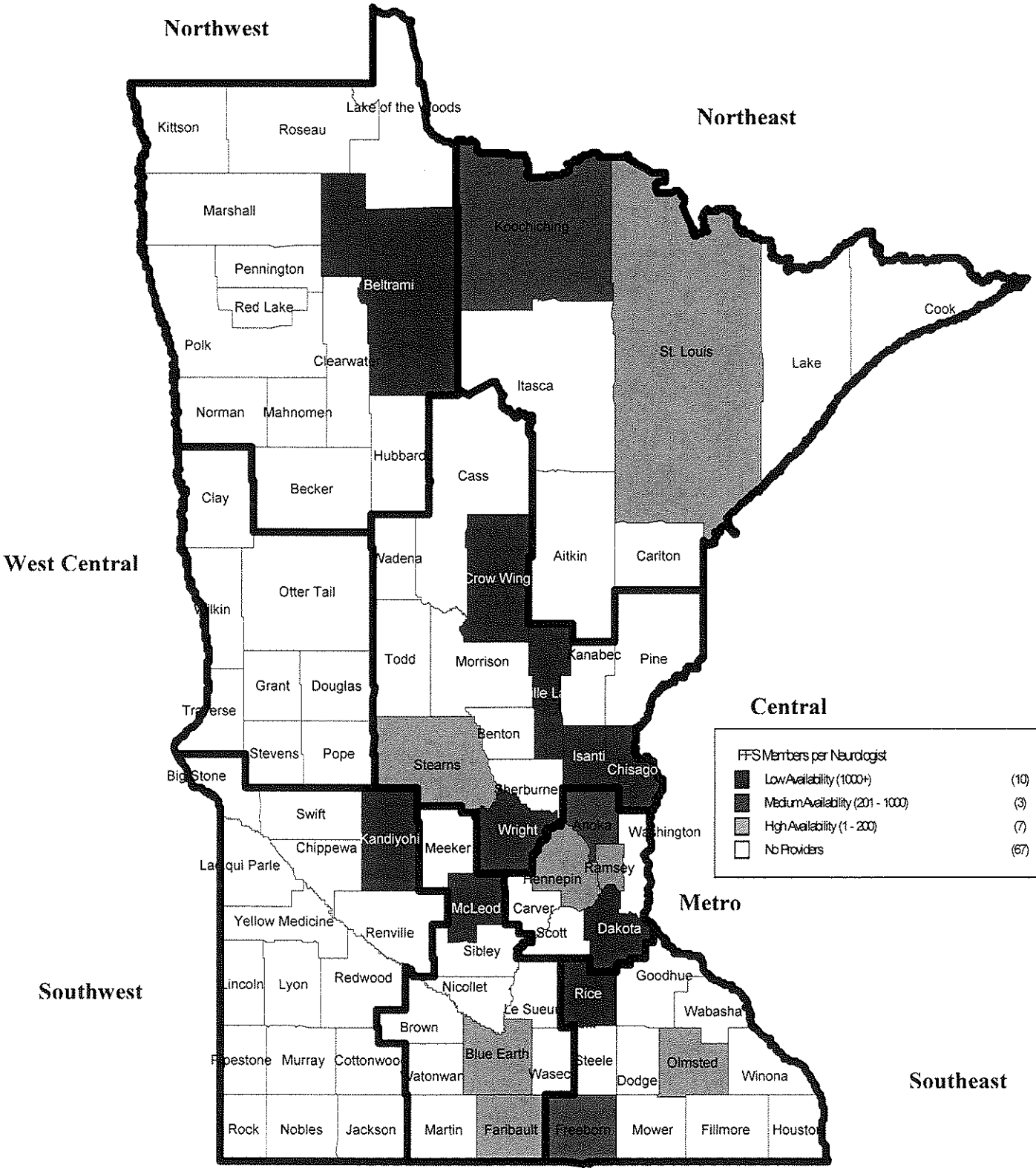
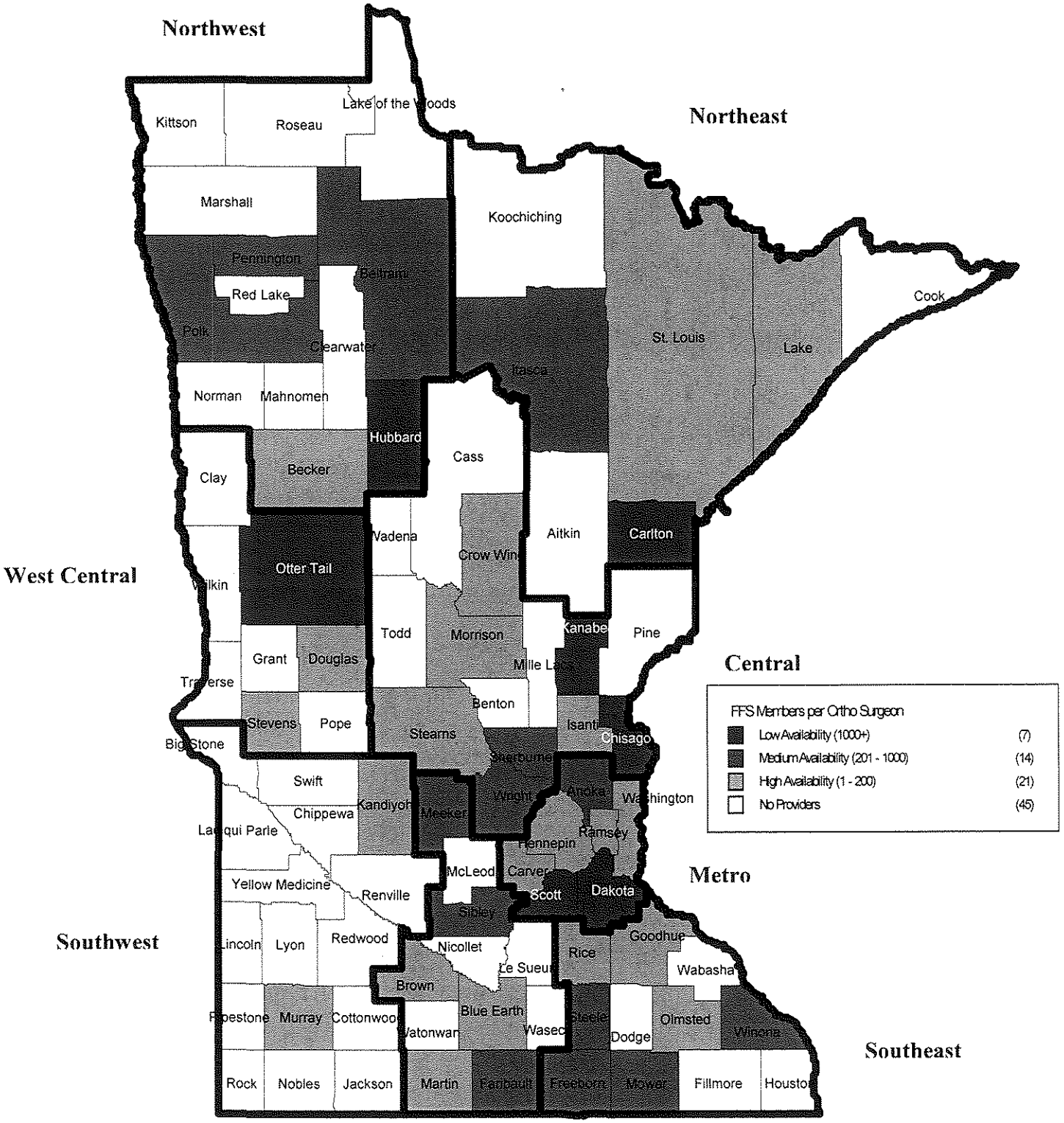


Exhibit 22
Fee-for-Service Members per Orthopedic Surgeon, By County, SFYs 2007-2008



Region Level Results for Selected Specialists

Exhibit 23 below explores the relationship between access to specific specialists in a region of the state (measured as FFS members per specialist) and utilization of services (measured as Visits per 1,000 FFS members) for these specialties. As was shown for primary care, FFS members may cross county lines to access services, so lower availability of specific specialties in a specific county may not necessarily infer low usage. Exhibit 23 focuses on OB/GYNs, psychiatrists, and dentists. The ratio of FFS members to OB/GYNs considers only female FFS members.

Of all regions, the Northwest has the lowest availability of OB/GYNs, psychiatrists and dentists (i.e., a much higher ratio f FFS members per specialist than the statewide average). Yet utilization is similar to the statewide average for OB/GYN visits and Dentist visits. This means that provider availability in the county does not appear to be impacting utilization. The lower availability of psychiatrists, however, may be impacting utilization in the Northwest Region since its psychiatrist utilization is lower than the statewide average. The only other service where lower availability may be having an effect on utilization is in the Southwest Region for psychiatrist services.

Exhibit 23
Availability and Utilization of OB/GYN, Psychiatrist, and Dental Services
For FFS Members by Region, SFYs 2007-2008

	OB/GYNs		Psychiatrists		Dentists	
	FFS Mbrs per OB/GYN	Visits per 1,000 Members	FFS Mbrs per Psychiatrist	Visits per 1,000 Members	FFS Mbrs per Dentist	Visits per 1,000 Members
Statewide	332	594	672	433	235	743
Relative comparison of ratios for each reason to the Statewide results						
Northwest Region	Much higher	Similar	Much higher	Lower	Much higher	Similar
Northeast Region	Higher	Similar	Higher	Similar	Similar	Similar
West Central Region	Much higher	Similar	Higher	Similar	Similar	Similar
Central Region	Higher	Similar	Much higher	Similar	Similar	Similar
Metro Region	Similar	Similar	Similar	Similar	Similar	Similar
Southwest Region	Much higher	Similar	Lower	Lower	Similar	Similar
South Central Region	Higher	Similar	Similar	Similar	Similar	Similar
Southeast Region	Lower	Similar	Similar	Similar	Similar	Similar

Much Higher ratio: Region ratio is more than 75% higher than the statewide ratio.
Higher ratio: Region ratio is between 25% and 75% higher than the statewide ratio.
Similar ratio: Region ratio is between 25% lower than and 25% higher than the statewide ratio.
Lower ratio: Region ratio is between 25% and 75% lower than the statewide ratio.
Much Lower ratio: Region ratio is more than 75% lower than the statewide ratio.

SECTION V: SUMMARY OF THE REPORT RELATED TO SURVEYING MEDICAID FEE-FOR-SERVICE BENEFICIARIES AND PARTICIPATING PHYSICIANS

The final report under this engagement relates to compiling findings from surveys sent to fee-for-service (FFS) Medicaid members and physicians. The intent of these surveys is to better understand members' views on provider availability (including ease of appointment setting and wait times) and physicians' views on the adequacy of rates. This section summarizes the methodology used to complete this analysis and findings from the report.

Methodology

Physician Survey

A 15-question survey was developed to gather more information from providers regarding their satisfaction with the current rates of reimbursement and the administration of the FFS program. The survey asks providers to rank the factors that might limit their participation in the program and for specific rate increases that would best encourage greater program participation.

The survey was piloted with a selection of providers that were invited by the Minnesota Medical Association (MMA) to participate. MMA members were also invited to complete a survey even if they were not included in the original sample that was sent surveys.

B&A intended to survey 1,100 in-state physicians (out of 9,638) with varying levels of participation in the FFS program. Providers in rural areas were oversampled in order to obtain feedback from regions with lower availability of providers in the state. The survey was sent out by mail in two waves. The first wave was sent to all 1,100 providers on March 10 with a request for responses by March 26. However, survey responses were accepted through April 26. Self-addressed, stamped return envelopes were provided. Due to a less-than-desired response rate, a second wave of the survey was sent out to all physicians that did not respond to the first wave. This second wave was sent out on March 31 with a response due date of April 17.

Address information was obtained from DHS for the physician survey. B&A received 149 surveys back due to an incorrect address or change in address with no forwarding information available. A total of 148 mail surveys were submitted to B&A. Therefore, of the net 951 surveys sent with a positive address, the response rate was 16 percent. An additional 13 were faxed to B&A by providers who were not sent a survey originally but had expressed interest to the MMA in participating. For most of the analyses, however, B&A was only able to use 97 of the survey responses due to incomplete surveys or lack of knowledge/interest of hospital-based physicians for questions related to reimbursement.

Member Survey

A total of 561 individuals (out of 16,250 potential recipients) participating in the Medicaid FFS program were sent a member survey. This 12-question mail survey asks members questions regarding items such as the period of time to obtain an appointment at a doctor's office, the wait time upon arrival at the office, and the level of difficulty faced in finding a primary care provider, specialist or dentist. The sample that was surveyed included in-state residents who had seen one of the physicians sent a provider survey.

B&A intended to survey 800 FFS members. However, the sample was reduced due to incurred or missing address on the DHS file, the member's death, or loss of Medicaid eligibility since December 2008. One wave of the survey was mailed out on March 12 with a request for responses by March 30.

Even after running this test, 24 surveys were returned to B&A due to incorrect address. There were 128 responses submitted to B&A. Therefore, of the net 537 surveys sent with a positive address, the response rate was 24 percent.

Findings

Related to the Physician Survey

- Among the 97 respondents (out of 1,1000 surveyed) used in the analysis, 13% stated that they had a solo practice, 58% stated that they were a member of a group practice, 23% stated that they were a salaried physician, and 5% did not answer the question.

- The majority of the respondents participate in both the Medicaid FFS program and the Medicaid managed care program (61%), 14% do not contract with a Medicaid managed care plan, and 25% did not answer the question. However, for almost half of the respondents, the Medicaid program (both FFS and managed care) represents less than 10% of their total business.

- Only seven physicians indicated that they limited their participation in the Medicaid FFS program. Of these, six of the seven cited reimbursement rates as the top reason.

- Physicians were asked to review a rate schedule that was provided with the survey which included the highest-volume service codes billed by physicians. When asked to estimate the level that the rates would need to be increased to cover their costs to deliver the services to Medicaid FFS members, over one quarter (28%) of the respondents indicated that the rates would need to at least be doubled, while over 80% stated that the rates needed to be increased by 40 percent or more.

- When asked for their satisfaction level about the rates shown on the survey's rate schedule, 89% of the respondents expressed some level of dissatisfaction with the rates and 73% were very unsatisfied. No respondent indicated that they were 'very satisfied' with the rates for high-volume services.

- Physicians were also asked to provide their opinion on Medicaid FFS rates overall as compared to other payers. Among the various payers queried, the Medicaid FFS program had the highest level of dissatisfaction (77% very unsatisfied and 13% somewhat unsatisfied), but the Medicaid managed care program was at almost the same level of dissatisfaction (70% very unsatisfied and 20% somewhat unsatisfied). This contrasts with the satisfaction levels of commercial payers. Physicians rated their satisfaction level with commercial managed care rates (very or somewhat satisfied) at 74% and with non-managed care commercial rates at 81%.

- Over half of the 79 respondents who provided suggestions of which services should receive priority for rate increases mentioned the evaluation and management (E&M) codes which are the high-volume service codes delivered by primary care providers.

- Physicians were also asked about their satisfaction with other aspects of the FFS program, including billing, prior authorization, and referrals to specialists. None of the items queried received a satisfaction rating above 50% except for 'range and number of specialists available for referrals' which received a 59% satisfaction rating.

Related to the Member Survey

- 87% of members have a personal doctor or nurse they see most of the time.

- Almost two-thirds of the respondents had seen their primary doctor three or more times during a recent nine-month period. More than half had seen another physician in the practice where their primary doctor works. More than half had also visited another doctor's office or clinic during this time period (such as a specialist).

- Over half of the members were able to obtain an appointment with their primary doctor when they needed care right away within one day and over three-quarters were able to obtain an appointment within two days. Findings were similar when asked about appointments at an office or clinic other than at the member's primary doctor office.

- About half of members said that they could obtain a routine appointment within a week either at their primary doctor's office or at another doctor's or clinic office.

- Over 40% of the members who responded to the question (44 out of 103) regarding use of alternative locations to the doctor's office indicated that they had used the hospital emergency room if they needed care right away. However, the majority of these members had only used the ER once or twice in the last nine months. B&A found a disproportionately higher response for ER usage among members in the Northeast Region of the state.

- When they went to see their primary doctor, more than half of the members (55%) reported waiting 15 minutes or less beyond the scheduled appointment time and over three-quarters (77%) waited less than 30 minutes.

- Members were asked the level of difficulty in finding different physician specialty types as well as dentists. Respondents could indicate if it was a 'big problem', 'small problem', 'no problem', or that they did not try to find the particular physician type. There were only two provider types that a majority of the respondents provided feedback on—personal doctor or nurse and dentists. Eighty percent of the respondents indicated no problem in finding a personal doctor or nurse, but only 54 percent indicated no problem in finding a dentist. When analyzed at the regional level, the difficulty in finding a dentist was concentrated in the northern and central parts of the state. Whereas the percentage of respondents reporting a 'big problem' in finding a dentist was 32% statewide, it was 63% in the Northeast Region, 67% in the Northwest Region, and 69% in the Central Region.

- Over 60% of survey respondents stated that they were 'very satisfied' and over 80% were either 'very satisfied' or 'somewhat satisfied' with the services they receive in the Medical Assistance program. Almost three-quarters of respondents (73%) believe that their ability to receive care in the Medical Assistance program is either the same or better than what they would receive with private insurance.

SECTION VI: RECOMMENDATIONS

Burns & Associates offers the following recommendations in light of the key findings discovered in the review of rates paid to physicians in the fee-for-service program:

1. Other than a one-time across the board increase of three percent in 2000, physicians have not received rate increases since the 1989 base year data was utilized. Since there have been essentially no rate adjustments since 1992, payments for office visits, maternity care and preventive medicine have deteriorated to 33% of charges (versus 62% in 1993) and to 31% of charges (versus 58% in 1993) for other physician services.

2. Minnesota pays physicians at most at 64% of the Medicare rates for primary care services. But this has probably deteriorated since the last comprehensive study of Medicare to Medicaid physician rates was completed in 2003 and since then Medicare has adopted inflationary increases where Minnesota DHS has not.

3. In a 2007/2008 study of selected pediatric rates, Minnesota paid at approximately 50% of Medicare's rates and at approximately 80% of the comparison states studied.

4. Although the number of actual of services is few, there are some situations where physicians are reimbursed at a lower level than nonphysicians in the FFS program.

5. Overall, thus far it does not appear that the rates paid in the FFS program has caused a systemic concern regarding access to care for FFS members, but there are some counties in the state where there is significantly lower provider availability (measured on a ratio of enrollees to physicians) than others. Improved rates may help to encourage further provider participation, but there may be other concerns expressed by providers and members once the results of the provider and member surveys are known.

Recommendations

1. The DHS should adopt the Medicare Resource-Based Relative Value Scale (RBRVS) as per Legislative mandate. Resources should be put towards implementation of this system as a base for further rate changes.

   Implemented in 1992, the Medicare RBRVS is a methodology that is based on three factors of "resource use": physician effort, practice expense and professional liability insurance. The resource use factors (called relative value units, or RVUs) for each service are multiplied by a standard "conversion factor" that is a dollar amount, to produce a reimbursement rate for each service. The resource use factors for specific services are reviewed annually by a review committee (that includes the American Medical Association among other organizations) to ensure that the factors reflect current practices. The resource use factors for all services are reviewed every five years. The "conversion factor" is reviewed and may be adjusted by Medicare annually.

   The RBRVS system is a national standard of reimbursement that virtually all physicians understand, is regarded as having equitable resource use factors for the various physician services, and is relatively easy to administer. Implementation of an RBRVS system will create a base for consistency and the ability to make modifications that will be inherently

more logical than the current FFS rate system. If the RBRVS is adopted, Minnesota should annually update the RVUs to coincide with Medicare's changes.

2. In adopting the RBRVS, the state should carefully consider the level it sets for the "conversion factor" used in the methodology. Numerous policy goals can be achieved through the adjustment of the conversion factor. For example:

    a. Since it is unlikely in the current economic situation that the state can afford physician payments at the Medicare rates, the conversion factor should be set at a level that will be budget neutral overall. In setting the conversion factor at this level, certain services will enjoy increases while others will experience decreases. However, equity in compensation between physician services will be achieved.

    b. If additional funding is available, this funding should be directed to services that the state values as a policy matter. This can be achieved by adopting a higher conversion factor for these "high value" services than is adopted for services generally. B&A recommends the state first direct any additional funding to evaluation and management physician services to encourage participation among primary care physicians and to reduce inappropriate ER use. This recommendation is supported in the feedback from the provider survey, where the majority of physicians that provided specific recommendations for rate increases stated that the high-volume evaluation and management services should be given highest priority.

    c. If the state wishes as a policy matter to differentiate between provider specialties (e.g., physicians and non-physicians) or by areas of the state, these goals can also be achieved through an adjustment in the conversion factor. In such cases, the conversion factor would differ depending on the provider type or the provider location.

    d. The state should adopt a policy goal of compensating physicians at a specified level of the Medicare rates. B&A recommends a target of 85% of the Medicare rates. As funding becomes available, the generally applied conversion factor can be increased.

3. In adopting the RBRVS, the state should explicitly state its policy goals and limit adjustments in the claims payment process to these goals. Any adjustments should be made transparent to providers. Publishing different conversion factors that may be implemented will eliminate much of the oblique pricing strategies currently in place.

APPENDIX A

Report to the Legislature: Comparison of Minnesota Medicaid Fee-for-Service Physician Rates to Rates Paid by Medicare and Selected Other States

Deliverable #4 under CFMS Contract #B23431

February 5, 2009

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SECTION I: INTRODUCTION

The Minnesota Department of Human Services (DHS), Health Services and Medical Management Division (HSMMD) retained Burns & Associates, Inc. (B&A) to evaluate the adequacy of availability of services (primary care and selected specialties) for fee-for-service members enrolled in the Minnesota Health Care Program (MHCP).

B&A is an independent health care consulting firm with a focus on state Medicaid programs. Among the firm's practice areas is the development and evaluation of programs, policies and provider rates. Under this engagement, B&A is to complete five deliverables, of which this report is *Deliverable #4: Comparison of Medicaid Fee-for-Service Physician Rates to Rates Paid by Medicare and Selected Other States*. Other deliverables include an evaluation of the provider rates paid by the Minnesota DHS to physicians and non-physicians delivering the same service, an examination of the availability of care to fee-for-service members, and a report on the results of physician and member surveys related to availability of care.

DHS is required to provide this report as a result of the Office of the Legislative Auditor's (OLA) February 2008 report "Financial Management of Health Care Programs[1]." In Chapter 3 of the report, "State Payment Rates for Health Care Programs," the OLA concluded that the Legislature and the DHS have not taken sufficient steps to address concerns about the adequacy and equity of Minnesota's fee-for-service rates. Specifically, the OLA recommended:

- DHS should report to the 2009 Legislature on the adequacy of Minnesota's fee-for-service provider rates. As part of this analysis, DHS should identify service areas or regions of the state in which public program enrollees have had difficulty accessing providers.

- The Legislature should consider increasing fee-for-service payment rates for certain types of providers, such as primary care physicians.

Minnesota's physicians are paid for services delivered to the fee-for-service (non-managed care) population at the lower of either:

1. Their submitted charge, or
2. The median rate established using 1989 data that is discounted 20% (for evaluation and management or OB/GYN services) or 25% (all other services)

Other than a one-time across the board increase of 3% in 2000, physicians have not received rate increases since the 1989 base year data was utilized, with one exception. Some mental health services provided by a psychiatrist received a 23.7% increase in addition to the 3% increase during this time period.

This report describes the methodology for selecting the comparative states, the physician services examined, the results of the rate comparison, and recommendations. The survey instrument that was distributed to the comparative states and a summary of the survey responses that were received are included as Appendices to the report.

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[1] The OLA report can be found at: http://www.auditor.leg.state.mn.us/ped/pedrep/healthcare.pdf
The discussion of fee-for-service rates is on pages 49-53 of the report.

SECTION II: METHODOLOGY

The methodology for collecting and comparing physician rates consisted of four steps:

- Selection of comparison states
- Selection of comparison physician services
- Developing and administering a survey instrument
- Collecting state Medicaid rates outside of the survey

Selection of Comparison States

Nine states were selected for comparison based on two primary criteria:

- Recommendations of the Health Services and Medical Management Division (HSMMD): Michigan, Oregon, Washington and Wisconsin

- States with physician rates (stated as a percentage of Medicare rates) that were at least 10 percentage points:
  - Higher than Minnesota (High Medicaid states): Iowa, Nebraska
  - Lower than Minnesota (Low Medicaid states): Indiana, Ohio

B&A added a ninth state, Vermont, because its Medicaid program is about to initiate a physician rate study of its own.

Attributes of the Comparison States

In order to provide some perspective of the sample states compared to Minnesota, Exhibits 1 and 2 are presented below. Exhibit 1 presents each of the comparison states' managed care enrollment as a percentage of total Medicaid enrollment. Exhibit 2 presents each of the comparison states' distribution of the Medicaid enrollment by category of eligibility.

At the outset, it should be understood that no two Medicaid programs are directly comparable, and without significant investment in detailed research, comparison data must be interpreted with caution. The information presented in Exhibits 1 and 2 illustrate some of the factors that should be kept in mind when comparing Medicaid programs.

Exhibit 1 shows that Minnesota ranks below all the HSMMD selected states but Wisconsin in managed care enrollment. Minnesota's managed care penetration is higher than Iowa and about the same as both the high and low Medicaid percentage states. The rate of Medicaid managed care penetration is significant because this report examines fee-for-service (i.e., non-managed care) rates.

Exhibit 1
Medicaid Managed Care Penetration in 2006

	Managed Care Enrollment as a Percent of Total Medicaid Enrollment
United States	**57%**
Minnesota	**62%**
Michigan	88%
Oregon	89%
Washington	86%
Wisconsin	48%
Iowa	37%
Nebraska	62%
Indiana	68%
Ohio	70%
Vermont	84%

Source: State Health Facts, 2006

Exhibit 2 compares the percentage of children, adults, elderly and disabled in each of the comparison states. Not all of the comparison states include the elderly and disabled in managed care. Since this report compares fee-for-service rates, it is important to note that if a state has a higher percentage of elderly and disabled, it would likely follow that these states have a larger fee-for-service population.

Exhibit 2
Percent Distribution of State Medicaid Populations

State	Children	Adults	Elderly	Disabled
Minnesota	**51%**	**23%**	**12%**	**14%**
Michigan	52%	24%	8%	16%
Oregon	49%	28%	9%	14%
Washington	51%	29%	7%	14%
Wisconsin	43%	29%	15%	14%
Iowa	53%	22%	10%	16%
Nebraska	59%	18%	8%	15%
Indiana	60%	19%	9%	13%
Ohio	53%	23%	8%	16%
Vermont	42%	33%	13%	13%

Source: CMS MSIS data, 2004

Selection of Comparison Physician Services

In order to determine which services would be compared between the states, B&A examined the Minnesota Medicaid claims file for services delivered to fee-for-service beneficiaries during the period July 1, 2006 through June 30, 2008. During this period, physicians filed over 3.1 million fee-for-service claims (5.2 million detail lines) with over 8,270 service codes (with each code representing a distinct service) and received payments of approximately $302 million. In order to distill this volume of services down to a manageable level, B&A undertook the following process:

Step 1: The Medicaid provider file was examined to determine the specialties listed for each physician. The physician's specialty was then assigned to each claim filed by that physician. The claims were then sorted by reported specialty and the highest volume specialties were selected for inclusion in the comparison.

Step 2: The results from Step 1 were matched to the full claims file. High-volume services (based on number of units billed and total payments) were selected to compare to other states. There were 29 visit, medication management and consultation codes that crossed multiple specialties. Other codes specific to each specialty were selected based on volume billed. In total, 67 unique physician codes were selected that included codes billed by the following specialties:

- Primary care 29 codes
- Pediatrics 25 codes
- OB/GYN 10 codes
- Psychiatry 8 codes
- Neurology 5 codes
- Orthopedic/Surgery 5 codes
- Cardiology 9 codes

Because some of the codes are used by multiple specialties, the unique number of services included in the comparison (67) is less than the sum above.

Finally, at the request of HSMMD, 11 high-volume dental service codes were also included for comparison.

The physician codes selected for comparison accounted for 44.6% ($134.2 million) of the $302 million paid to physicians over the two years through the FFS program and the dental codes selected accounted for 39.9% ($23.3 million) of the $58 million paid to dentists over the two years through the FFS program.

Developing and Administering the Survey

To gather data from the comparison states for the analysis, B&A prepared a survey (see Appendix A) that asked for rate and programmatic information. The desired rate- related information included: basis for rate development, total annual payments by code, total annual service units by code, and per member per month (PMPM) service units and dollars. The programmatic information included any available evaluations of physician participation rates and any evaluations or anecdotal information on access to care issues, including out of state referrals.

Prior to distributing the survey, B&A identified contacts from each state and discussed the survey with them.

Unfortunately, the timing for the survey could not have been worse. Almost uniformly, the comparison states indicated their desire to participate but with the current fiscal crises confronting the states, the necessity for each state's Medicaid agency to develop budget options, other materials and impact estimates of the proposed federal stimulus package for their legislatures currently in session, staff time was at a premium. Some states flatly indicated that completion of the survey at this time was not feasible.

In order to assist the comparison states and to generate information for this analysis, B&A found on the internet each state's fee schedule and the AAP's fee information and populated the fee portion of each survey. The surveys were then distributed to the states with a request for confirmation of the fees.

Only three states returned the survey—Nebraska, Ohio, Wisconsin; however these surveys were incomplete. The states answered the simple questions that did not require accessing data: questions 1-3 (relating to basis of the fee schedule, analyses of access to care questions and court challenges) and questions 8-11 (relating again to access to care, performance and quality incentives, and comparison to commercial payors). The states did not supply the data requested on units of service, annual payments, and physician participation rates.

However, through follow-up phone calls, some of the states provided B&A with additional information and all the states confirmed their fee schedules. The results gleaned from the states that provided responses are included in Appendix B.

After the budget and stimulus package storm calms, some states indicated they would complete the survey.

SECTION III: FINDINGS

It should be noted at the outset that Minnesota's DHS is not unusual among Medicaid agencies nationwide in that a payment rate is placed on file for a particular service (often called the "base rate") but there may be adjustments—both upward and downward—to the base rate in certain circumstances. These adjustments typically are a result of legislation targeting changes in payments to specific provider types or for specific services. This "special pricing" is usually not reflected in a state's published fee schedule. The base rate on file is only the starting point of the pricing calculation.

Special pricing was found in many of the services examined for this report. Examples of special pricing in Minnesota's fee-for-service system include, but are not limited to, the following:

- Pediatric services are paid a 15% upward adjustment from the base rate
- Obstetric providers receive a 26.5% upward adjustment from the base rate
- Community and public health clinics receive a 20% upward adjustment from the base rate
- Advance practice nurses receive a 10% reduction from the physician's rate
- Physicians receive a 40% downward adjustment from the base rate when the service is delivered in an outpatient hospital setting instead of in a doctor's office
- The Courage Center (a Minnesota-based rehabilitation center) receives a 38% upward adjustment from the base rate

What is unknown from each state surveyed is the level of special pricing that is used to make upward or downward adjustments. This is because the special pricing is often conditional in nature and cannot be quantified across-the-board.

Another cautionary note is potential differences between states in the interpretation of service codes with respect to the scope of service. In some situations, part of a service definition includes the amount of time, for example, for a visit. There are occasions where a visit's time duration may not be stated in the nationally-recognized definition, so states interpret different time allotments when using the service code. This will influence the payment made for the service.

Therefore, the findings in this section are limited to a comparison of the base rates in place in Minnesota's fee-for-service program as compared to the base rates in place at other Medicaid programs using national definitions for each service code. Average payment rates (when measured by volume) may differ quite a bit from what is shown for each state and may.

Summary

Section III compares the fee-for-service rates in three broad categories of physician services between nine states stratified into three groups. The three broad categories of services[2] are Medication Management, Visit and Consultation; Pediatrics; and Selected Specialties and Pediatrics. The three stratified groups of states include HSMMD selected states, high Medicaid states relative to Medicare (called "high Medicaid" going forward) and low Medicaid states relative to Medicare (called "low Medicaid" going forward).

[2] The specific services reviewed are organized by their Current Procedural Terminology and Healthcare Common Procedure Coding System (CPT/HCPCS) codes used by medical practitioners to bill for services.

The comparisons presented lead to the following key findings:

- Minnesota's fee-for-service rates for the Pediatric Preventive and Initial Visit codes are extremely low compared to all of the states included in this review. Comparison states' rates are at least 72% higher than Minnesota's rates for these services. This finding is supported by the results of the American Academy of Pediatrics' 2007/2008 study that ranked Minnesota's rates for six key pediatric services approximately 45th of the 48 reporting states. Minnesota also has low rates for OB/GYN specialty services, particularly in the maternity service codes.

- An additional area of concern for Minnesota should be its fee-for-service Office/Outpatient rates for both new and continuing patients. All states reviewed in this report have Office/Outpatient rates that are higher than Minnesota. These services represent the single largest billing category for physicians, and the State's low rates may lead to potential access problems. Other states are at least 5% higher than Minnesota, and the state with the highest rates for these services (Iowa) is approximately 74% higher.

- Minnesota's Emergency and Critical Care fee-for-service rates are also low relative to the comparison states – seven of the comparison states have higher rates – and these other states' rates tend to be about 20% higher than Minnesota.

- The Dental fee-for-service rates in the State are also low; only three of the comparison states have lower rates.

- Minnesota does have some categories of specialty rates that are higher than the comparison states – both the Neurology and Orthopedic Surgery specialties receive higher fee-for-service rates than the comparison states.

- Viewing Minnesota's rates on a state by state basis leads to the conclusion that the State's fee-for-service rates appear to be significantly lower than two of the HSMMD selected states – Oregon and Washington – while they are probably slightly higher than Michigan and are most likely higher than Wisconsin. Minnesota's rates are lower than the rates of the two identified high Medicaid states and probably higher than the two low Medicaid states.

The balance of Section III presents a more detailed review of Minnesota's fee-for-service rates compared to Medicare and the other selected states.

Comparison to Medicare

Exhibit 3 shown on the next page illustrates the ratio of the weighted average Medicaid FFS rates to the Medicare rates for all physician services, primary care services only, and obstetric care services only. The data reflects rates tabulated from 2003 (the most recent compilation available) by the Kaiser Family Foundation[3]. The nine states that were surveyed to compare their Medicaid FFS rates to Minnesota's are shown in the Exhibit. The states are stratified among the four groups identified above.

[3] http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4

Minnesota's physician rates overall were paid at 79% of the Medicare rates in 2003, but primary care rates were paid at 64% of the Medicare rates and obstetric care rates were paid at 82% of the Medicare rates. Although the overall Medicaid-to-Medicare ratio places Minnesota above the national average when compared to other state Medicaid programs to Medicare's rates, the primary care and obstetric ratios are at the national average when compared to other states. Among the comparison states, Minnesota ranks in the middle for their Medicaid-to-Medicare ratio for primary care services and 7th lowest out of the ten for obstetric services.

Despite these findings, this data is still not fully representative of the situation in 2009. This is because the Medicare RBRVS program applies inflationary adjustments to its rates each year whereas Minnesota has not provided any increase since 2003. Therefore, Minnesota's Medicaid-to-Medicare ratios are actually lower today than what is shown in Exhibit 3.

Exhibit 3
Medicaid Fee-for-Service Physician Rates as a Percentage of Medicare Rates, 2003

	Ratio of Medicaid to Medicare Rates		
	All Physician Services	Primary Care Only	Obstetric Care Only
United States	**69%**	**62%**	**84%**
Minnesota	**79%**	**64%**	**82%**
Michigan	62%	63%	60%
Oregon	86%	75%	117%
Washington	87%	79%	122%
Wisconsin	87%	73%	101%
Iowa	97%	94%	101%
Nebraska	95%	78%	94%
Indiana	68%	60%	77%
Ohio	68%	66%	79%
Vermont	83%	64%	114%

Source: www.statehealthfacts.org

Because the data presented in Exhibit 3 is five years old, B&A searched for more timely data. The most credible result from this search was found at the American Academy Pediatrics (AAP)[4]. Exhibit 4 shown on the next page presents a few of the high-volume codes billed be pediatricians from the AAP 2007/2008 study for the comparative states.

Exhibit 4 displays the fee-for-service Medicaid rates paid to pediatricians for three established patient visits and three new patient visits. Also contained in the Exhibit are the following: the percentage that each service fee is of the average fee of the comparison states (Minnesota is generally at about 80% of the comparative states' average), the national ranking of the fee against the 48 states that submitted data (Minnesota consistently ranked about 45th), and each state's fee

[4] 2007/08 AAP Medicaid Reimbursement Survey. American Academy of Pediatrics. Elk Grove Village, Illinois

as a percentage of the Medicare fee (Minnesota paid the lowest percentage of Medicare fees in four of the six services depicted and the second lowest in the other two services).

Although not depicted in the Exhibit, a comparison between the Medicare percentages in the Exhibit and the similar percentages in Exhibit 3 reveals that all the comparison states except Washington and Vermont are paying a lower percentage of the Medicare rate in 2007/2008 than they were paying in 2003. However, this observation should be tempered—Exhibit 4 only displays six pediatric fees while the percentages displayed in Exhibit 3 are based on all the services performed by physicians.

Exhibit 4

American Academy of Pediatricians' Analysis of Selected Codes Paid to Pediatricians: 2007/2008 Survey

	Established Patient Codes											
	99212				99213				99214			
State	Amount	% of Average for Similar States	National Rank	% of Medicare	Amount	% of Average for Similar States	National Rank	% of Medicare	Amount	% of Average for Similar States	National Rank	% of Medicare
MN	$20.60	86.3%	45	56.9%	$24.72	71.8%	47	41.9%	$46.14	87.9%	41	51.7%
MI	$21.96	92.0%	42	varies	$29.93	86.9%	41	varies	$46.94	89.4%	40	varies
OR	$26.47	110.9%	35	76.5%	$36.07	104.7%	35	63.4%	$56.57	107.7%	35	65.6%
WA	$32.77	137.3%	14	90.7%	$53.46	155.2%	9	91.0%	$80.82	153.9%	10	90.8%
WI	$23.41	98.1%	41	67.1%	$32.30	93.8%	38	56.6%	$56.57	107.7%	34	65.4%
IA	$32.36	135.5%	16	85.4%	$44.61	129.5%	18	77.5%	$68.93	131.3%	19	76.6%
NE	$28.68	120.1%	30	96.3%	$43.02	124.9%	21	80.4%	$64.53	122.9%	27	81.9%
IN	$18.20	76.2%	49	53.2%	$25.98	75.4%	46	46.1%	$40.43	77.0%	45	47.3%
OH	$24.74	103.6%	40	70.0%	$34.35	99.7%	36	59.6%	$52.57	100.1%	37	60.1%
VT	$44.94	175.3%	4		$61.55	170.8%	3		$96.54	169.3%	2	
Average	**$23.87**				**$34.45**				**$52.51**			

	New Patient Codes											
	99382				99204				99205			
State	Amount	% of Average for Similar States	National Rank	% of Medicare	Amount	% of Average for Similar States	National Rank	% of Medicare	Amount	% of Average for Similar States	National Rank	% of Medicare
MN	$35.43	58.6%	45	30.3%	$61.80	78.5%	45	45.0%	$90.64	90.3%	38	52.6%
MI	$86.72	143.4%	14	varies	$77.94	99.1%	36	varies	$99.04	98.7%	36	varies
OR	$71.10	117.6%	26	79.9%	$93.94	119.4%	32	70.6%	$119.37	119.0%	33	71.3%
WA	$71.60	118.4%	23	80.4%	$125.37	159.3%	9	91.0%	$157.83	157.3%	11	91.2%
WI	$56.96	94.2%	34	59.7%	$118.15	150.2%	13	88.0%	$163.25	162.7%	7	96.7%
IA	$91.55	151.4%	9	106.0%	$121.58	154.5%	12	93.2%	$151.57	151.1%	13	92.3%
NE	$90.82	150.2%	10	102.7%	$95.60	121.5%	30	73.4%	$124.68	124.3%	30	75.8%
IN	$39.85	65.9%	44	36.4%	$70.14	89.1%	40	53.1%	$88.36	88.1%	40	53.2%
OH	$50.70	83.9%	33	59.9%	$70.32	89.4%	39	51.7%	$87.97	87.7%	42	51.5%
VT	$109.01	165.0%	4		$159.79	172.3%	2		$203.29	169.0%	2	
Average	**$60.46**				**$78.69**				**$100.34**			

Comparison of State Rates

The comparison of rates for the selected primary and specialty physician codes are presented in Exhibits 5 through 10 at the end of this section. The exhibits are set up in pairs. Exhibits 5, 7 and 9 present the dollar amount per unit (rate) for the selected services for each of the comparison states. Exhibits 6, 8 and 10 present each comparison state's rate as a percentage of the Minnesota rate. Percentages above 100% indicate that the rate for the service in the particular state is greater than Minnesota's rate; conversely, percentages below 100% indicate that the rate for the service is less than Minnesota's rate.

Exhibits 6, 8 and 10 also contain highlighted lines labeled "Average Percentage of MN" after groups (or sub-groups) of services. The lines are inserted as a summary point for relatively similar services, such as "Office/Outpatient visits" or "Inpatient hospital-related visits".

The percentages presented on these lines are *simple averages* of the percentages presented for the various groups or sub-groups of services. The averages are not *weighted averages* that would allow the reader to reach conclusions about the absolute percentage differences in the fee schedules between states. The percentages on the "Average Percentage of MN" lines are intended to help the reader draw conclusions from an extensive amount of data.

The exhibits are organized in the following manner:

- Exhibits 5 and 6 present information related to Medication Management, Visit and Consultation codes
- Exhibits 7 and 8 present information related to Pediatric codes
- Exhibits 9 and 10 present information related to Selected Specialty codes

Medication Management, Visit and Consultation Codes

The collection of services on Exhibits 5 and 6 can be billed by both primary and specialty physicians and represent the "bread and butter" billing codes for physicians.

In examining Exhibit 6 from a service perspective, it appears:

- Minnesota's medication management rate is higher than any of the comparison states. The Minnesota rate is nearly twice the HSMMD selected states' rates, between 20% and 30% higher than the high Medicaid states' rates and between 38% and 47% higher than the low Medicaid states' rates.

- With respect to the Office/Outpatient visit average rates for both new and established patients, all the states have higher average rates than Minnesota. The HSMMD selected states have average rates that are between 12% and 48% higher; the high Medicaid states have average rates that are between 47% and 74% higher; and the low Medicaid states are between 5% and 24% higher than Minnesota. This Office/Outpatient visit group of codes is the most frequently billed group of services by both primary and specialist physicians.

- Results are less consistent for most of the other depicted Visit, Medication Management and Consultation groups of services:

- For the subgroup of Inpatient codes, only three comparison states have codes higher than Minnesota: one is a HSMMD selected state (Oregon) and the other two are the high Medicaid states. The states with higher rates are between 10% and 28% higher while the states with the lower average rates are between 6% and 35% lower.

- For the Inpatient Consultation groups of codes and the Office Consults, it is a similar story to the Inpatient codes – four states are either equal to or higher than Minnesota, with Oregon again being the highest among the HSMMD selected states, and the two high Medicaid states being equal to or higher than Minnesota.

- However, for the Emergency and Critical Care group of codes, seven of the comparison states have average rates equal to or higher than Minnesota. The largest difference is 66%, with most of other states trending toward rates that are 20% higher than Minnesota.

From a state comparative basis, the data in Exhibits 5 and 6 seems to indicate that Minnesota's average Medication Management, Visit and Consultation rates are, on balance:

- With respect to the HSMMD selected states: well below the Oregon average rates, below the Washington rates, probably above Michigan's, and well above Wisconsin's

- Well below the two high Medicaid states and also below the low Medicaid state of Indiana, and probably higher than Ohio's – but not in the frequently billed group of Office and Outpatient visits

Pediatric Codes

Exhibit 7 and 8 are the "paired" tables that present the rate information for selected Pediatric services. The majority of the rates depicted in these exhibits is drawn from the American Academy of Pediatrics 2007/2008 study and represent the most frequent codes billed by pediatricians. These rates are from the same source as the information previously presented in Exhibit 4.

In examining Exhibit 8 from a pediatric service perspective, it appears:

- All states are roughly equal with respect to the 90378 respiratory service rate.

- All states have considerably higher (7% to 149%) average Office/Outpatient rates than Minnesota.

- For Inpatient visits, the average rate results are almost evenly split among the states: three states have higher rates (by as much as 30%) than Minnesota and five states have lower rates (by as much as 34%).

- For Office Consultations, the states are again about equally split for the average rates: four states are equal to or higher than Minnesota (by as much as 36%) and four states are lower (by as much as 31%).

- For Emergency pediatric services, virtually all of the comparison states have equal (one state) or higher (six states) rates, with Wisconsin recording the lowest rate at 62% of the Minnesota rate.

- Because Minnesota pays Pediatric Critical and Intensive care "by report" (meaning that it is paid as a function of each physician's billed charges), comparisons cannot be made to the other states.

- The most shocking comparison on Exhibit 3.6 relates to Preventive and Initial Pediatric care – all states have considerably higher average rates than Minnesota. The other states' average rates are at least 72% higher (for the low Medicaid states) and as much as 151% higher (for the high Medicaid states). The HSMMD selected states have average rates for these services that are between 83% and 177% higher than Minnesota's.

From a state comparative basis, Exhibits 7 and 8 seem to indicate that Minnesota's average Pediatric rates are on balance:

- Well below the rates paid in the HSMMD selected states of Oregon, Washington and Wisconsin, and about on par (though with a different mix) with Michigan

- Clearly below the high Medicaid states of Iowa and Nebraska, but also below the low Medicaid state of Indiana; Minnesota's rates are probably higher than Ohio's – but not in the area of pediatric preventive care

Selected Specialty Codes

Exhibits 9 and 10 are the "paired" tables that present the rate information for Selected Specialty codes. The exhibits present the rates associated with the previously identified five specialty areas as well as the dental codes in the following order: OB/GYN, Psychiatric, Neurology, Orthopedic Surgeon, Cardiologist and Dental.

In examining Exhibit 10 from a service perspective, it appears:

- For OB/GYN services, Minnesota has the lowest average rate of all the states except Indiana, a low Medicaid state. The other states have average rates that range from 9% higher than Minnesota (Nebraska) to 50% higher (Oregon). The data indicates that the Minnesota rates are lower in virtually all of the depicted Maternity codes, but generally higher in the Exam codes.

- The rates for Psychiatric services have an interesting pattern. While five of the comparison states have average rates that are equal to or greater than Minnesota's, an examination of the specific services is revealing. All of the comparison states have significantly higher rates for Psychiatric Interviews and Group Psychotherapy (by margins of as much as 249%), but four of these states have lower Office treatment rates (Psychiatric treatment, office). Minnesota has the highest rates of the states with rates for short term residential day treatments.

- Minnesota's average rates for Neurology are the highest of all of the comparison states.

- Similarly, Minnesota's average rates (and most of the specific rates) in the depicted Orthopedic Surgeon services group are higher than all of the comparison states.

- For Cardiologist services, three of the states have higher average rates than Minnesota but all states have higher rates for the two services of Doppler Color Flow and Left Heart Catheterization.

- With respect to Dental services, only three states have lower average rates than Minnesota – and these three states are all HSMMD selected states.

From a state comparative basis, Exhibits 9 and 10 seem to indicate that Minnesota's average Selected Specialty rates are on balance:

- With respect to the HSMMD selected states: probably about the same as Michigan and Washington and probably lower than Oregon and Wisconsin

- Lower than the two high Medicaid states and higher than the two low Medicaid states

Exhibit 5
Medication Management, Visit and Consultation Codes: Other States' FFS Rates Compared to Minnesota's FFS Rates

			HSMMD Selected				Hi Medicaid		Low Medicaid		
CPT/HCPCS Code	Procedure Description	MN	MI	OR	WA	WI	IA	NE	IN	OH	VT
90862	Medication Management	$60.48	$29.50	$38.44	$32.90	$32.00	$48.89	$41.24	$37.23	$31.99	$44.09
99201	Office/Outpatient Visit, New Pat, 10 min	$27.19	$20.88	$26.61	$25.12	$22.00	$38.38	$31.07	$20.82	$21.81	$35.61
99202	Office/Outpatient Visit, New Pat, 20 min	$30.48	$37.03	$46.50	$43.71	$37.01	$60.26	$45.41	$33.96	$36.05	$63.30
99203	Office/Outpatient Visit, New Pat, 30 min	$36.25	$55.12	$68.81	$63.80	$55.33	$84.81	$66.92	$47.44	$53.48	$93.99
99204	Office/Outpatient Visit, New Pat, 45 min	$61.80	$77.94	$105.37	$97.72	$79.16	$122.80	$95.60	$73.51	$81.55	$133.16
99205	Office/Outpatient Visit, New Pat, 60 min	$90.64	$99.04	$132.52	$123.34	$100.71	$153.09	$124.28	$93.13	$102.47	$169.41
99211	Office/outpatient visit, est. patient, 5 min	$12.36	$12.27	$14.78	$13.56	$12.19	$18.87	$16.73	$9.98	$13.43	$20.94
99212	Office/outpatient visit, est. patient, 10 min	$20.60	$21.96	$27.42	$25.87	$21.96	$32.68	$28.68	$19.37	$24.75	$37.45
99213	Office/outpatient visit, est. patient, 15 min	$24.72	$30.65	$44.62	$42.20	$30.30	$45.06	$43.02	$31.96	$40.38	$51.29
99214	Office/outpatient visit, est. patient, 25 min	$46.14	$46.94	$67.74	$63.55	$47.65	$69.62	$64.53	$48.54	$61.24	$80.45
99215	Office/outpatient visit, est. patient, 45 min	$65.92	$68.25	$91.93	$85.91	$69.83	$104.18	$93.21	$65.25	$82.99	$117.06
99221	Initial hosp care, physician bedside 30 min	$54.07	$38.75	$65.32	$54.02	$60.63	$67.71	$45.88	$54.05	$37.61	$66.38
99222	Initial hosp care, physician bedside 50 min	$100.42	$64.16	$91.39	$74.47	$66.79	$111.54	$80.74	$80.67	$55.71	$110.19
99223	Initial hosp care, physician bedside 70 min	$112.01	$89.35	$133.32	$109.59	$76.46	$149.65	$104.60	$108.09	$76.84	$153.63
99231	Subseq hosp care, physician bedside 15 min	$30.12	$19.38	$27.42	$22.45	$20.62	$34.57	$27.53	$24.86	$17.49	$33.28
99232	Subseq hosp care, physician bedside 25 min	$34.76	$31.65	$48.92	$40.46	$25.82	$54.07	$44.04	$40.35	$28.18	$54.52
99233	Subseq hosp care, physician bedside 35 min	$92.70	$45.00	$69.89	$57.80	$40.42	$76.07	$73.40	$57.47	$40.28	$77.47
99238	Hospital discharge day mgmt, <= 30 min	$40.94	$40.26	$50.00	$40.90	$37.97	$64.43	$66.06	$44.05	$31.62	$69.29
99239	Hospital discharge day mgmt, > 30 min	$59.84	$54.90	$72.31	$58.91	$78.42	$84.74	$110.10	$62.86	$41.78	$47.02
99242	Office Consultation, 30 min	$60.25	$52.32	$66.93	$55.35	$58.11	$86.93	$62.39	$59.27	$39.00	$88.99
99243	Office Consultation, 40 min	$78.79	$69.76	$91.93	$75.80	$79.27	$111.24	$80.74	$81.03	$53.41	$118.71
99244	Office Consultation, 60 min	$113.55	$98.39	$135.48	$112.04	$99.07	$154.84	$102.76	$121.18	$78.63	$168.02
99245	Office Consultation, 80 min	$135.18	$127.24	$168.27	$138.27	$100.07	$201.34	$139.46	$148.04	$97.57	$217.34
99253	Initial Inpatient Consultation, 55 min	$78.79	$56.19	$83.33	$68.69	$79.27	$98.44	$84.41	$76.19	$49.25	$96.06
99254	Initial Inpatient Consultation, 80 min	$113.55	$80.74	$119.88	$99.37	$88.72	$138.23	$110.10	$110.64	$69.17	$138.53
99255	Initial Inpatient Consultation, 110 min	$135.18	$111.31	$149.18	$122.49	$99.07	$188.79	$146.80	$133.68	$92.32	$190.98
99283	Emergency Dept. Visit, mid-level	$37.46	$35.31	$46.50	$37.57	$22.98	$61.62	$49.55	$43.82	$35.55	$60.12
99284	Emergency Dept. Visit, mid-level	$50.98	$55.12	$85.21	$69.58	$27.26	$94.87	$58.72	$75.73	$59.35	$93.87
99291	Critical Care, First 30-74 min	$123.60	$145.97	$193.80	$157.61	$88.97	$184.04	$154.14	$165.99	$98.58	$249.95

Exhibit 6
Medication Management, Visit and Consultation Codes: Other States' FFS Rates as a Percentage of Minnesota's FFS Rates

		HSMMD Selected				High Medicaid		Low Medicaid		
CPT/HCPCS Code	Procedure Description	MI	OR	WA	WI	IA	NE	IN	OH	VT
90862	Medication Management	49%	64%	54%	53%	81%	68%	62%	53%	73%
99201	Office/Outpatient Visit, New Pat, 10 min	77%	98%	92%	81%	141%	114%	77%	80%	131%
99202	Office/Outpatient Visit, New Pat, 20 min	121%	153%	143%	121%	198%	149%	111%	118%	208%
99203	Office/Outpatient Visit, New Pat, 30 min	152%	190%	176%	153%	234%	185%	131%	148%	259%
99204	Office/Outpatient Visit, New Pat, 45 min	126%	171%	158%	128%	199%	155%	119%	132%	215%
99205	Office/Outpatient Visit, New Pat, 60 min	109%	146%	136%	111%	169%	137%	103%	113%	187%
99211	Office/outpatient visit, est. patient, 5 min	99%	120%	110%	99%	153%	135%	81%	109%	169%
99212	Office/outpatient visit, est. patient, 10 min	107%	133%	126%	107%	159%	139%	94%	120%	182%
99213	Office/outpatient visit, est. patient, 15 min	124%	181%	171%	123%	182%	174%	129%	163%	207%
99214	Office/outpatient visit, est. patient, 25 min	102%	147%	138%	103%	151%	140%	105%	133%	174%
99215	Office/outpatient visit, est. patient, 45 min	104%	139%	130%	106%	158%	141%	99%	126%	178%
	Average Percentage of MN	**112%**	**148%**	**138%**	**113%**	**174%**	**147%**	**105%**	**124%**	**191%**
99221	Initial hosp care, physician bedside 30 min	72%	121%	100%	112%	125%	85%	100%	70%	123%
99222	Initial hosp care, physician bedside 50 min	64%	91%	74%	67%	111%	80%	80%	55%	110%
99223	Initial hosp care, physician bedside 70 min	80%	119%	98%	68%	134%	93%	97%	69%	137%
99231	Subseq hosp care, physician bedside 15 min	64%	91%	75%	68%	115%	91%	83%	58%	110%
99232	Subseq hosp care, physician bedside 25 min	91%	141%	116%	74%	156%	127%	116%	81%	157%
99233	Subseq hosp care, physician bedside 35 min	49%	75%	62%	44%	82%	79%	62%	43%	84%
99238	Hospital discharge day mgmt, <= 30 min	98%	122%	100%	93%	157%	161%	108%	77%	169%
99239	Hospital discharge day mgmt, > 30 min	92%	121%	98%	131%	142%	184%	105%	70%	79%
	Average Percentage of MN	**76%**	**110%**	**90%**	**82%**	**128%**	**113%**	**94%**	**65%**	**121%**
99242	Office Consultation, 30 min	87%	111%	92%	96%	144%	104%	98%	65%	148%
99243	Office Consultation, 40 min	89%	117%	96%	101%	141%	102%	103%	68%	151%
99244	Office Consultation, 60 min	87%	119%	99%	87%	136%	90%	107%	69%	148%
99245	Office Consultation, 80 min	94%	124%	102%	74%	149%	103%	110%	72%	161%
	Average Percentage of MN	**89%**	**118%**	**97%**	**90%**	**143%**	**100%**	**104%**	**68%**	**152%**
99253	Initial Inpatient Consultation, 55 min	71%	106%	87%	101%	125%	107%	97%	63%	122%
99254	Initial Inpatient Consultation, 80 min	71%	106%	88%	78%	122%	97%	97%	61%	122%
99255	Initial Inpatient Consultation, 110 min	82%	110%	91%	73%	140%	109%	99%	68%	141%
	Average Percentage of MN	**75%**	**107%**	**88%**	**84%**	**129%**	**104%**	**98%**	**64%**	**128%**
99283	Emergency Dept. Visit, mid-level	94%	124%	100%	61%	164%	132%	117%	95%	160%
99284	Emergency Dept. Visit, mid-level	108%	167%	136%	53%	186%	115%	149%	116%	184%
99291	Critical Care, First 30-74 min	118%	157%	128%	72%	149%	125%	134%	80%	202%
	Average Percentage of MN	**107%**	**149%**	**121%**	**62%**	**166%**	**124%**	**133%**	**97%**	**182%**

Exhibit 7
Pediatric Codes: Other States' FFS Rates Compared to Minnesota's FFS Rates

			HSMMD Selected				Hi Medicaid		Low Medicaid		
CPT/HCPCS Code	Procedure Description	MN	MI	OR	WA	WI	IA	NE	IN	OH	VT
90378	Respiratory syncytial virus immune globulin, 50 mg	$901.54	$828.10	$899.41	*	$839.66	$778.35	By Report	$1,060.63	$876.35	$536.24
99212	Office/outpatient visit, established patient, 10 min	$20.60	$21.96	$27.42	$45.64	$21.96	$32.68	$28.68	$19.37	$24.75	$37.45
99213	Office/outpatient visit, established patient, 15 min	$24.72	$30.65	$44.62	$74.44	$30.30	$45.06	$43.02	$31.96	$40.38	$51.29
99214	Office/outpatient visit, established patient, 25 min	$46.14	$46.94	$67.74	$112.09	$47.65	$69.62	$64.53	$48.54	$61.24	$80.45
99215	Office/outpatient visit, established patient, 45 min	$65.92	$68.25	$91.93	$151.52	$69.83	$104.18	$93.21	$65.25	$82.99	$117.06
99222	Initial hospital care, physician bedside 50 min	$100.42	$64.16	$91.39	$74.47	$66.79	$111.54	$80.74	$80.67	$55.71	$110.19
99223	Initial hospital care, physician bedside 70 min	$112.01	$89.35	$133.32	$109.59	$76.46	$149.65	$104.60	$108.09	$76.84	$153.63
99232	Subsequent hospital care, physician bedside 25 min	$34.76	$31.65	$48.92	$40.46	$25.82	$54.07	$44.04	$40.35	$28.18	$54.52
99233	Subsequent hospital care, physician bedside 35 min	$92.70	$45.00	$69.89	$57.80	$40.42	$76.07	$73.40	$57.47	$40.28	$77.47
99238	Hospital discharge day management, 30 min or less	$40.94	$40.26	$50.00	$40.90	$37.97	$64.43	$66.06	$44.05	$31.62	$69.29
99239	Hospital discharge day management, more than 30 min	$59.84	$54.90	$72.31	$58.91	$78.42	$84.74	$110.10	$62.86	$41.78	$47.02
99244	Office consultation, 60 minutes	$113.55	$98.39	$135.48	$112.04	$99.07	$154.84	$102.76	$121.18	$78.63	$168.02
99283	Emergency dept visit, mid-level	$37.46	$35.31	$46.50	$37.57	$22.98	$61.62	$33.03	$43.82	$35.55	$60.12
99284	Emergency dept visit, mid-level	$50.98	$55.12	$85.21	$69.58	$27.26	$94.87	$58.72	$75.73	$59.35	$93.87
99291	Critical care, first 30-74 min	$123.60	$145.97	$193.80	$157.61	$88.97	$184.04	$154.14	$165.99	$98.58	$249.95
99294	Pediatric critical care, per day, child 29 days-24 mo	By Rpt	*	$287.08	*	$363.89	$386.18	$238.55	$292.81	Not Covered	$399.98
99295	Pediatric critical care, per day, child < 29 days old	By Rpt	*	$665.55	*	$507.67	$772.46	$550.50	$673.60	Not Covered	$919.91
99296	Subsequent pediatric critical care, child < 29 days old	By Rpt	*	$286.81	*	$355.38	$386.18	$293.60	$294.51	Not Covered	$402.58
99298	Subsequent intensive care, body weight <1500g	By Rpt	*	$101.88	*	$128.68	$139.86	$126.25	$105.87	Not Covered	$141.65
99299	Subsequent intensive care, body weight 1500-2500g	By Rpt	*	$94.08	*	$117.86	$127.74	$73.40	$96.94	Not Covered	$129.41
99300	Subsequent intensive care, body weight 2501-5000g	By Rpt	*	$90.59	*	$113.32	$123.04	$73.40	$91.25	Not Covered	$0.00
99391	Preventive visit, age under one year	$25.54	$71.06	$54.84	$76.20	$57.53	$75.46	$76.48	$50.43	$47.59	$76.85
99392	Preventive visit, age 1-4 years	$25.95	$79.59	$61.29	$87.28	$57.53	$83.30	$81.26	$56.00	$52.97	$86.06
99394	Preventative Visit, Est, 12-17	$28.84	$86.77	$66.93	$101.02	$57.53	$93.87	$90.82	$61.69	$58.36	$93.97
99431	Initial care, normal newborn	$49.82	$50.64	$42.20	*	$108.43	$72.17	$105.16	$55.33	Not Covered	$59.25

* Code not listed or blank

Exhibit 8
Pediatric Codes: Other States' FFS Rates as a Percentage of Minnesota's FFS Rates

		HSMMD Selected				High Medicaid		Low Medicaid		
CPT/HCPCS Code	Procedure Description	MI	OR	WA	WI	IA	NE	IN	OH	VT
90378	Respiratory syncytial virus immune globulin, 50 mg	92%	100%	N/A	93%	86%	By Report	118%	97%	59%
99212	Office/outpatient visit, established patient, 10 min	107%	133%	222%	107%	159%	139%	94%	120%	182%
99213	Office/outpatient visit, established patient, 15 min	124%	181%	301%	123%	182%	174%	129%	163%	207%
99214	Office/outpatient visit, established patient, 25 min	102%	147%	243%	103%	151%	140%	105%	133%	174%
99215	Office/outpatient visit, established patient, 45 min	104%	139%	230%	106%	158%	141%	99%	126%	178%
	Average Percentage of MN	**109%**	**150%**	**249%**	**110%**	**162%**	**149%**	**107%**	**136%**	**185%**
99222	Initial hospital care, physician bedside 50 min	64%	91%	74%	67%	111%	80%	80%	55%	110%
99223	Initial hospital care, physician bedside 70 min	80%	119%	98%	68%	134%	93%	97%	69%	137%
99232	Subsequent hospital care, physician bedside 25 min	91%	141%	116%	74%	156%	127%	116%	81%	157%
99233	Subsequent hospital care, physician bedside 35 min	49%	75%	62%	44%	82%	79%	62%	43%	84%
99238	Hospital discharge day management, 30 min or less	98%	122%	100%	93%	157%	161%	108%	77%	169%
99239	Hospital discharge day management, more than 30 min	92%	121%	98%	131%	142%	184%	105%	70%	79%
	Average Percentage of MN	**79%**	**112%**	**92%**	**79%**	**130%**	**121%**	**95%**	**66%**	**123%**
99244	Office consultation, 60 minutes	87%	119%	99%	87%	136%	90%	107%	69%	148%
99283	Emergency dept visit, mid-level	94%	124%	100%	61%	164%	88%	117%	95%	160%
99284	Emergency dept visit, mid-level	108%	167%	136%	53%	186%	115%	149%	116%	184%
99291	Critical care, first 30-74 min	118%	157%	128%	72%	149%	125%	134%	80%	202%
99294	Pediatric critical care, per day, child 29 days-24 mo	**	**	**	**	**	**	**	N/A	**
99295	Pediatric critical care, per day, child < 29 days old	**	**	**	**	**	**	**	N/A	**
99296	Subsequent pediatric critical care, child < 29 days old	**	**	**	**	**	**	**	N/A	**
99298	Subsequent intensive care, body weight <1500g	**	**	**	**	**	**	**	N/A	**
99299	Subsequent intensive care, body weight 1500-2500g	**	**	**	**	**	**	**	N/A	**
99300	Subsequent intensive care, body weight 2501-5000g	**	**	**	**	**	**	**	N/A	**
	Average Percentage of MN	**107%**	**149%**	**121%**	**62%**	**166%**	**109%**	**133%**	**97%**	**182%**
99391	Preventive visit, age under one year	278%	215%	298%	225%	295%	299%	197%	186%	301%
99392	Preventive visit, age 1-4 years	307%	236%	336%	222%	321%	313%	216%	204%	332%
99394	Preventative Visit, Est, 12-17	301%	232%	350%	199%	325%	315%	214%	202%	326%
99431	Initial care, normal newborn	102%	85%	not available	218%	145%	211%	111%	N/A	119%
	Average Percentage of MN	**247%**	**183%**	**277%**	**185%**	**251%**	**250%**	**174%**	**172%**	**252%**

** Since Minnesota allows payment 'by report' for these codes, a percentage cannot be calculated; N/A means noncovered service by the state

Exhibit 9, Part I
Selected Specialist Codes: Other States' FFS Rates Compared to Minnesota's FFS Rates

CPT/HCPCS Code	Procedure Description	MN	HSMMD Selected				Hi Medicaid		Low Medicaid		
			MI	OR	WA	WI	IA	NE	IN	OH	VT
OB GYN Type Services											
57454	Vagina Exam and Biopsy	$122.05	$91.50	$112.63	$90.48	$129.92	$97.78	$129.25	$71.32	$120.34	$123.54
59409	Maternity Care and Delivery	$469.68	$688.66	$876.72	$902.12	$618.55	$798.86	$778.89	$657.63	$637.72	$931.18
59410	Obstetrical Care	$494.40	$755.30	$995.75	$1,041.35	$660.79	$880.50	$927.25	$698.37	$731.10	$966.23
59425	Maternity Care and Delivery	$194.77	$292.24	$465.11	$500.79	$295.75	$323.10	$57.34	$40.57	N/A	$37.89
59426	Maternity Care and Delivery	$354.93	$489.88	$828.92	$895.49	$507.10	$553.32	$57.34	$43.73	N/A	$37.89
76805	Echo Exam of Pregnant Uterus	$89.83	$77.51	$99.72	$86.47	$135.91	$124.80	$121.43	$94.94	$99.87	$114.10
76811	Ob, us, detailed, sngl fetus	$217.88	$143.61	$170.69	$132.94	$214.57	$214.86	$204.08	$169.29	$174.90	$216.33
76815	Echo Exam of Pregnant Uterus	$57.16	$51.89	$65.32	$55.13	$90.69	$83.65	$79.28	$63.40	$66.98	$74.96
76817	Transvaginal us, obstetric	*	$56.41	$71.50	$60.69	$84.95	$86.33	$86.67	$68.41	$69.18	$65.04
J7302	Levonorgestrel iu contracept	$556.60	$496.83	$496.83	$503.87	$468.71	$482.45	N/A	$585.89	$468.71	$468.71
Psychiatric Type Services											
90801	Psychiatric Interview - 30 Min Unit	$43.47	$86.77	$136.17	$92.92	$150.04	$135.05	$126.53	$80.90	$92.25	$75.99
90805	Psytx, office (20-30) w/e&m	$61.23	$40.91	$68.09	$43.13	$75.02	$67.04	$57.36	$51.02	$45.52	$56.55
90806	Psytx, office (45-50)	$75.60	$55.98	$102.13	$55.58	$150.04	$91.87	$104.10	$63.67	$57.27	$58.81
90807	Psytx, office (45-50) w/e&m	$113.40	$59.64	$102.13	$61.35	$150.04	$97.71	$107.02	$71.24	$63.72	$74.54
90853	Group Psychotherapy	$13.23	$18.30	$46.12	$19.12	$37.51	$11.18	$39.33	$19.23	$19.27	$15.37
90870	Electroconvulsive Therapy	$148.17	$83.11	$103.49	$85.81	$159.36	$91.59	$53.88	$68.95	$55.00	$31.46
H0018	Behav Hlth; Short-term Resid., Day	$262.00	$202.56	$126.13	$151.50	*	*	$242.68	$0.00	*	$180.00
H2012	Behav Hlth Day Treatment, Per Hr	$20.41	*	$0.01	$15.24	*	*	$40.88	$0.00	*	*

* For Minnesota: means covered 'By Report; for other states: code not available or blank

N/A means not covered by the state

Exhibit 9, Part II
Selected Specialist Codes: Other States' FFS Rates Compared to Minnesota's FFS Rates

CPT/HCPCS Code	Procedure Description	MN	HSMMD Selected				Hi Medicaid		Low Medicaid		
			MI	OR	WA	WI	IA	NE	IN	OH	VT
Neurology Type Services											
95816	Electroencephalogram (EEG) Awake/Drowsy	$78.28	$106.79	$106.61	$128.04	$105.76	$123.55	$77.07	$72.61	$84.47	$61.74
95860	Muscle Test, One Limb	$142.91	$52.75	$26.34	$51.57	$74.78	$69.71	$64.23	$57.01	$48.23	$68.00
95903	Motor Nerve Conduction Test	*	$39.62	$25.00	$38.90	$59.90	$42.33	$49.55	$32.84	$28.52	$39.69
95904	Sense Nerve Conduction Test	$38.62	$31.65	$24.46	$30.01	$38.07	$29.58	$36.70	$24.51	$22.35	$29.40
95951	EEG Monitoring/Video Record	$751.90	$996.97	$0.01	By Report	$594.82	$771.32	$495.45	$348.48	$369.75	$396.90
Orthopedic Surgeon Type Services											
20610	Drain/Inject Joint/Bursa	$41.71	$39.83	$50.53	$42.01	$64.65	$68.88	$29.83	$35.08	$48.91	$19.63
20680	Removal of Support Implant	$285.05	$273.65	$81.12	$331.23	$229.09	$260.16	$243.58	$187.18	$214.09	$133.56
64721	Carpal Tunnel Surgery	$570.87	$223.70	$289.77	$232.97	$511.41	$343.02	$417.56	$253.56	$254.17	$259.77
73221	Magnetic Image, Joint of Arm	$668.21	$290.01	$370.41	$321.89	$475.52	$466.17	$361.69	$328.61	$372.17	$456.40
73721	Magnetic Image, Joint of Leg	$668.21	$290.01	$372.29	$325.67	$475.52	$466.17	$361.69	$328.61	$372.17	$560.23
Cardiologist Type Services											
78465	Myocardial Perf Image, Tomograph, Mult	$560.83	$311.54	$381.96	$311.89	$526.37	$491.45	$410.55	$369.71	$394.55	$548.82
92980	Insert Intracoronary Stent, Sing Vessel	$880.35	$471.94	$604.80	$505.07	$799.58	$993.78	$1,156.05	$858.98	$770.32	$856.64
93010	Electrocardiogram Report	$14.67	$5.17	$6.45	$5.34	$8.84	$10.47	$21.11	$9.06	$8.15	$12.23
93307	Echo Exam of Heart	$173.81	$116.26	$141.93	$114.26	$191.69	$196.29	$216.53	$152.26	$151.53	$160.44
93320	Doppler Echo Exam, Heart	$76.16	$51.03	$62.63	$50.46	$84.08	$85.71	$102.76	$72.09	$66.43	$76.15
93325	Doppler Color Flow	$61.80	$69.54	$71.23	$45.79	$112.82	$107.92	$115.61	$78.93	$81.76	$85.67
93350	Echo Exam of Heart	$308.37	$86.12	$126.07	$119.60	$142.68	$113.20	$266.08	$186.61	$98.52	$168.40
93510	Left Heart Catheterization	$463.50	$994.04	$1,198.11	$900.76	$1,622.15	$1,560.63	$1,504.70	$1,167.49	$1,175.83	$400.13
93545	Injection for Coronary Xrays	$309.00	$12.27	$15.86	$76.92	$21.02	$35.98	$80.74	$77.44	$15.92	$33.72
Dental Services											
D0120	Periodic Oral Evaluation	$18.70	$14.89	$24.07	$22.00	$13.14	$16.63	$16.00	$22.58	$17.08	$18.00
D0150	Comprehensive Oral Evaluation	$25.50	$14.89	$37.44	$27.00	$19.95	$23.91	$16.00	$35.50	$26.35	$583.93
D0330	Panoramic Film	$46.75	$17.56	$23.31	$27.00	$38.10	$46.77	$34.00	$64.52	$46.32	$48.00
D1110	Adult Prophylaxis	$26.50	$22.10	$37.81	$37.37	$26.92	$36.38	$31.00	$47.75	$34.13	$39.00
D2150	Amalgam - Two Surfaces	$41.65	$31.21	$47.39	$48.38	$42.38	$59.25	$63.00	$81.14	$54.00	$73.00
D2391	Post 1 Srfc Resin Based Cmpst	$50.29	$15.59	$37.68	$36.04	$41.31	$53.00	$63.00	$55.50	$51.21	$90.00
D2392	Post 2 Srfc Resin Based Cmpst	$61.97	$31.21	$47.39	$48.38	$53.17	$73.60	$80.00	$64.50	$54.00	$133.00
D4341	Peridont Scaling/Root Planning Per Quad	$86.15	*	$64.24	$26.28	$76.92	$103.94	$100.00	$154.74	N/A	$84.00
D5110	Complete Upper	$474.45	$341.25	$360.67	$459.09	$438.06	$540.47	$570.00	$436.35	$400.00	$605.00
D5214	Mandibular Partial Denture	$556.09	$380.22	$360.67	$550.91	$375.88	$600.19	$500.00	$788.25	$540.25	$638.00
D7140	Extraction Erupted Tooth/ext	$44.70	$25.62	$77.90	$33.14	$39.76	$51.97	$52.00	$77.24	$52.45	$583.93

* For Minnesota: means covered 'By Report; for other states: code not available or blank

N/A means not covered by the state

Exhibit 10, Part I
Selected Specialist Codes: Other States' FFS Rates as a Percentage of Minnesota's FFS Rates

CPT/HCPCS Code	Procedure Description	HSMMD Selected				High Medicaid		Low Medicaid		
		MI	OR	WA	WI	IA	NE	IN	OH	VT
OB/GYN Services										
57454	Vagina Exam and Biopsy	75%	92%	74%	106%	80%	106%	58%	99%	101%
59409	Maternity Care and Delivery	147%	187%	192%	132%	170%	166%	140%	136%	198%
59410	Obstetrical Care	153%	201%	211%	134%	178%	188%	141%	148%	195%
59425	Maternity Care and Delivery	150%	239%	257%	152%	166%	29%	21%	N/A	19%
59426	Maternity Care and Delivery	138%	234%	252%	143%	156%	16%	12%	N/A	11%
76805	Echo Exam of Pregnant Uterus	86%	111%	96%	151%	139%	135%	106%	111%	127%
76811	Ob, us, detailed, sngl fetus	66%	78%	61%	98%	99%	94%	78%	80%	99%
76815	Echo Exam of Pregnant Uterus	91%	114%	96%	159%	146%	139%	111%	117%	131%
76817	Transvaginal us, obstetric	**	**	**	**	**	**	**	**	**
J7302	Levonorgestrel iu contracept	89%	89%	91%	84%	87%	N/a	105%	84%	84%
	Average Percentage of MN	**111%**	**150%**	**148%**	**129%**	**136%**	**109%**	**86%**	**111%**	**107%**
Psychiatric Services										
90801	Psychiatric Interview - 30 Min Unit	200%	313%	214%	345%	311%	291%	186%	212%	175%
90805	Psytx, office (20-30) w/e&m	67%	111%	70%	123%	109%	94%	83%	74%	92%
90806	Psytx, office (45-50)	74%	135%	74%	198%	122%	138%	84%	76%	78%
90807	Psytx, office (45-50) w/e&m	53%	90%	54%	132%	86%	94%	63%	56%	66%
90853	Group Psychotherapy	138%	349%	145%	284%	85%	297%	145%	146%	116%
90870	Electroconvulsive Therapy	56%	70%	58%	108%	62%	36%	47%	37%	21%
H0018	Behav Hlth; Short-term Resid., Day	77%	48%	58%	not available	not available	93%	0%	not available	69%
H2012	Behav Hlth Day Treatment, Per Hr	**	**	**	**	**	**	**	**	**
	Average Percentage of MN	**95%**	**159%**	**96%**	**198%**	**129%**	**149%**	**87%**	**100%**	**88%**

** Since Minnesota allows payment 'by report' for these codes, a percentage cannot be calculated; N/A means noncovered service by the state

Exhibit 10, Part II
Selected Specialty Codes: Other States' FFS Rates as a Percentage of Minnesota's FFS Rates

CPT/HCPCS Code	Procedure Description	HSMMD Selected				High Medicaid		Low Medicaid		
		MI	OR	WA	WI	IA	NE	IN	OH	VT
Neurology Services										
95816	Electroencephalogram (EEG) Awake/Drowsy	136%	136%	164%	135%	158%	98%	93%	108%	79%
95860	Muscle Test, One Limb	37%	18%	36%	52%	49%	45%	40%	34%	48%
95903	Motor Nerve Conduction Test	**	**	**	**	**	**	**	**	**
95904	Sense Nerve Conduction Test	82%	63%	78%	99%	77%	95%	63%	58%	76%
95951	EEG Monitoring/Video Record	133%	0%	By Report	79%	103%	66%	46%	49%	53%
	Average Percentage of MN	**97%**	**54%**	**92%**	**91%**	**96%**	**76%**	**61%**	**62%**	**64%**
Orthopedic Surgeon Services										
20610	Drain/Inject Joint/Bursa	95%	121%	101%	155%	165%	72%	84%	117%	47%
20680	Removal of Support Implant	96%	28%	116%	80%	91%	85%	66%	75%	47%
64721	Carpal Tunnel Surgery	39%	51%	41%	90%	60%	73%	44%	45%	46%
73221	Magnetic Image, Joint of Arm	43%	55%	48%	71%	70%	54%	49%	56%	68%
73721	Magnetic Image, Joint of Leg	43%	56%	49%	71%	70%	54%	49%	56%	84%
	Average Percentage of MN	**63%**	**62%**	**71%**	**93%**	**91%**	**68%**	**59%**	**70%**	**58%**
Cardiologist Services										
78465	Myocardial Perf Image, Tomograph, Mult	56%	68%	56%	94%	88%	73%	66%	70%	98%
92980	Insert Intracoronary Stent, Sing Vessel	54%	69%	57%	91%	113%	131%	98%	88%	97%
93010	Electrocardiogram Report	35%	44%	36%	60%	71%	144%	62%	56%	83%
93307	Echo Exam of Heart	67%	82%	66%	110%	113%	125%	88%	87%	92%
93320	Doppler Echo Exam, Heart	67%	82%	66%	110%	113%	135%	95%	87%	100%
93325	Doppler Color Flow	113%	115%	74%	183%	175%	187%	128%	132%	139%
93350	Echo Exam of Heart	28%	41%	39%	46%	37%	86%	61%	32%	55%
93510	Left Heart Catheterization	214%	258%	194%	350%	337%	325%	252%	254%	86%
93545	Injection for Coronary Xrays	4%	5%	25%	7%	12%	26%	25%	5%	11%
	Average Percentage of MN	**71%**	**85%**	**68%**	**117%**	**117%**	**137%**	**97%**	**90%**	**85%**
Dental Services										
D0120	Periodic Oral Evaluation	80%	129%	118%	70%	89%	86%	121%	91%	96%
D0150	Comprehensive Oral Evaluation	58%	147%	106%	78%	94%	63%	139%	103%	2290%
D0330	Panoramic Film	38%	50%	58%	81%	100%	73%	138%	99%	103%
D1110	Adult Prophylaxis	83%	143%	141%	102%	137%	117%	180%	129%	147%
D2150	Amalgam - Two Surfaces	75%	114%	116%	102%	142%	151%	195%	130%	175%
D2391	Post 1 Srfc Resin Based Cmpst	31%	75%	72%	82%	105%	125%	110%	102%	179%
D2392	Post 2 Srfc Resin Based Cmpst	50%	76%	78%	86%	119%	129%	104%	87%	215%
D4341	Peridont Scaling/Root Planning Per Quad	not available	75%	31%	89%	121%	116%	180%	N/A	98%
D5110	Complete Upper	72%	76%	97%	92%	114%	120%	92%	84%	128%
D5214	Mandibular Partial Denture	68%	65%	99%	68%	108%	90%	142%	97%	115%
D7140	Extraction Erupted Tooth/ext	57%	174%	74%	89%	116%	116%	173%	117%	1306%
	Average Percentage of MN	**61%**	**102%**	**90%**	**85%**	**113%**	**108%**	**143%**	**104%**	**441%**

** Since Minnesota allows payment 'by report' for these codes, a percentage cannot be calculated; N/A means noncovered service by the state

SECTION IV: RECOMMENDATIONS

This report has identified a number of areas where Minnesota's fee-for-service physician rate schedule appears to be deficient. As stated previously, the findings discussed below are limited to a comparison of Minnesota's base rates to other state's base rates. What is unknown is the level to which other states, like Minnesota, utilize special pricing under certain circumstances based on the provider specialty or the location where the service is delivered. A brief summary of these apparent deficiencies includes:

- A rate setting mechanism – the lower of either charges or the 1989 median charge level – that is arbitrary and devoid of policy direction
- Physician rates that are losing ground to Medicare rates because of the absence of rate increases
- Rates that are significantly lower than other selected states for physician services that enrollees of public health care programs tend to consume – pediatrics, OB/GYN, emergency and critical care
- Relatively low rates for dental services, a health care area that public programs have notorious difficulties in attracting providers
- Lack of transparency of the "true" rate paid to a provider due to the various legislatively-enacted pricing considerations made over the years to select providers or services

Based on the information contained in this report, there are a number of areas where Minnesota should consider public policy changes. However, the perspective of this report is relatively narrow – how Minnesota's physician rates compare to other states.

The take-away from this report is that based on an evaluation of the services that constitute approximately half of the fee-for-service system's expenditures for physicians, the Minnesota physician rates should be increased. Specific recommendations that can be made at this time appear below.

1. Regardless of the level of payment made to physicians, B&A recommends that the DHS should adopt the Medicare Resource-Based Relative Value Scale (RBRVS) as per Legislative mandate. Resources should be put towards implementation of this system as a base for further rate changes. Implemented in 1992, the Medicare RBRVS is a methodology that is based on three factors of "resource use": physician effort, practice expense and professional liability insurance. The resource use factors (called relative value units, or RVUs) for each service are multiplied by a standard "conversion factor" that is a dollar amount to produce a reimbursement rate for each service. The resource use factors for specific services are reviewed annually by a review committee (that includes the American Medical Association among other organizations) to ensure that the factors reflect current practices. The resource use factors for all services are reviewed every five years. The "conversion factor" is reviewed and may be adjusted by Medicare annually.

2. Implementation of an RBRVS system will create a base for consistency and the ability to make modifications that will be inherently more logical than the current FFS rate system. If the RBRVS is adopted, Minnesota should annually update the RVUs to coincide with Medicare's changes. However, understanding fiscal realities that the State may not be able to pay Medicaid physicians at the same rate as Medicare physicians, the DHS should use the conversion factor to make this downward adjustment and to preserve the integrity of the RVUs established by Medicare and endorsed by the AMA.

3. Notwithstanding the current economic climate, the Legislature is encouraged to set a future target payment rate of 85% of the Medicare rate in order to conform to the level that other state Medicaid agencies pay their providers.

APPENDIX A

THE SURVEY INSTRUMENT DISTRIBUTED TO COMPARISON STATES

MEDICAID PHYSICIAN FEES
SURVEY OF STATES

1. The physician fee schedule used by Medicaid Fee-for-Service (FFS) in your state is based on:

_____ Medicare RBRVS

If yes, please describe in the space below the frequency of updates to the fee schedule and any state specific revisions made to RBRVS.

_____ Usual and Customary

If yes, please describe the base year for the fee schedule and any routine or periodic updates made to the schedule in the space below.

_____ Other

If yes, please describe the basis of the fee schedule including the base year and any routine or periodic updates made.

2. Has the state or another entity conducted an analysis of access to care for physician services in the Fee-for-Service (FFS) program?

Yes_____ No_____

If yes, please attach the study(ies) with your response.

Please describe the state's methodology for reimbursement of nonphysician practitioners providing the same service as a physician.

3. Have providers or recipients challenged the state in court on access to physician services under the FFS program?

Yes_____ No_____

If yes, please describe the litigation briefly and if resolved, the resolution.

4. Please provide the following information regarding physicians and other independent practitioners of medical services participating in the Medicaid program:

Number of MDs and DOs participating in Medicaid _____
Does the figure include only those with active claims in SFY 2008?
Yes_____ No_____

Number of Nurse Practitioners
Does the figure include only those with active claims in SFY 2008?
Yes_____ No_____

Number of Physician Assistants
Does the figure include only those with active claims in SFY 2008?
Yes_____ No_____

5. Please provide the following information regarding Medicaid eligibles for SFY2008:

	Fee for Service	Managed Care
Children <21		
Unduplicated Annual		
Average Monthly Eligibles		
Adults (Parents and Singles)		
Unduplicated Annual		
Average Monthly Eligibles		
Aged and Disabled Nonduals		
Unduplicated Annual		
Average Monthly Eligibles		
Total Medicaid		
Unduplicated Annual		
Average Monthly Eligibles		

Do any of the numbers provided include SCHIP? Yes_____ No_____

If yes, which numbers and how many SCHIP are included?

6. Please provide the following information for Fee-for-Service spending only for SFY 2008:

Physician Services Expenditures _____
Nurse Practitioner/PA Expenditures _____
Total FFS Expenditures _____

Do expenditures include the FFS window for managed care enrollees?

Yes_____ No_____

Can you separate these expenditures? If yes, please provide the expenditures without the FFS window.

Physician Services Expenditures _____
Nurse Practitioner/PA Expenditures _____
Total FFS Expenditures _____

7. Please provide information on the number of licensed practitioners as well as licensed and practicing practitioners in the state:

	Licensed		Licensed and Practicing
Physicians (MD and DO)		Physicians (MD and DO)	
Nurse Practitioners		Nurse Practitioners	
Physician Assistants		Physician Assistants	

8. In its FFS program, has the state taken any steps to improve access to physicians or physician extenders? If yes, please describe these steps or attach a description.

9. Does the state have tracking mechanisms in place to assess access to primary and specialty services? If yes, please describe these mechanisms or attach a description.

10. Does the state utilize any pay for performance or quality incentives in its FFS physician program? If yes, please describe or attach a description.

11. Does the state have information on how its physician fees compare to commercial payers in the state? If yes, please attach or describe.

12. Please complete the following tables for physician fees.

VISIT, MEDICATION MANAGEMENT AND CONSULTATION CODES

CPT/ HCPCS CODE	Procedure Description	Medicaid Fee	Enhanced Rate for Specialty (e.g. OB GYN)	Enhanced Rate for _____	Enhanced Rate for _____	SFY 2008 Units of Service	SFY 2008 Spending
90862	Medication Management						
99201	Office/Outpatient Visit, New						
99202	Office/Outpatient Visit, New						
99203	Office/Outpatient Visit, New						
99204	Office/Outpatient Visit, New						
99205	Office/Outpatient Visit, New						
99211	Office/Outpatient Visit, Est.						
99212	Office/Outpatient Visit, Est.						
99213	Office/Outpatient Visit, Est.						
99214	Office/Outpatient Visit, Est.						
99215	Office/Outpatient Visit, Est.						
99221	Initial Hospital Care						
99222	Initial Hospital Care						
99223	Initial Hospital Care						
99231	Subsequent Hospital Care						
99232	Subsequent Hospital Care						
99233	Subsequent Hospital Care						
99238	Hospital Discharge Day						
99239	Hospital Discharge Day						
99242	Office Consultation						
99243	Office Consultation						
99244	Office Consultation						
99245	Office Consultation						
99253	Initial Inpatient Consultation						
99254	Initial Inpatient Consultation						
99255	Initial Inpatient Consultation						
99283	Emergency Dept. Visit						
99284	Emergency Dept. Visit						
99291	Critical Care, First Hour						

PRIMARY CARE AND SPECIALTY CODES

CPT/HCPCS Code	Procedure Description	Medicaid Fee	SFY 2008 Units of Service	SFY 2008 Spending
PCP Type Services				
99294	Ped. Critical Care, Subseq.			
99394	Preventative Visit, Est, 12-17			
OB GYN Type Services				
57454	Vagina Exam and Biopsy			
59409	Maternity Care and Delivery			
59410	Obstetrical Care			
59425	Maternity Care and Delivery			
59426	Maternity Care and Delivery			
76805	Echo Exam of Pregnant Uterus			
76811	Ob, us, detailed, sngl fetus			
76815	Echo Exam of Pregnant Uterus			
76817	Transvaginal us, obstetric			
J7302	Levonorgestrel iu contracept			
Psychiatric Type Services				
90801	Psychiatric Interview - 30 Min Unit			
90805	Psytx, office (20-30) w/e&m			
90806	Psytx, office (45-50)			
90807	Psytx, office (45-50) w/e&m			
90853	Group Psychotherapy			
90870	Electroconvulsive Therapy			
H0018	Behav Hlth; Short-term Resid., Day			
H2012	Behav Hlth Day Treatment, Per Hr			
Neurology Type Services				
95816	Electroencephalogram (EEG) Awake/Drowsy			
95860	Muscle Test, One Limb			
95903	Motor Nerve Conduction Test			
95904	Sense Nerve Conduction Test			
95951	EEG Monitoring/Video Record			
Orthopedic Surgeon Type Services				
20610	Drain/Inject Joint/Bursa			
20680	Removal of Support Implant			
64721	Carpal Tunnel Surgery			
73221	Magnetic Image, Joint of Arm			
73721	Magnetic Image, Joint of Leg			
Cardiologist Type Services				
78465	Myocardial Perf Image, Tomograph, Mult			
92980	Insert Intracoronary Stent, Sing Vessel			
93010	Electrocardiogram Report			
93307	Echo Exam of Heart			
93320	Doppler Echo Exam, Heart			
93325	Doppler Color Flow			
93350	Echo Exam of Heart			
93510	Left Heart Catheterization			
93545	Injection for Coronary Xrays			
Dental Services				
D0120	Periodic Oral Evaluation			
D0150	Comprehensive Oral Evaluation			
D0330	Panoramic Film			
D1110	Adult Prophylaxis			
D2150	Amalgam - Two Surfaces			
D2391	Post 1 Srfc Resin Based Cmpst			
D2392	Post 2 Srfc Resin Based Cmpst			
D4341	Peridont Scaling/Root Planning Per Quad			
D5110	Complete Upper			
D5214	Mandibular Partial Denture			
D7140	Extraction Erupted Tooth/ext			

If your state pays enhanced fees to any types of providers for these codes please attach or describe these enhanced fees.

APPENDIX B

RESPONSES RECEIVED FOR COMPARISON STATES

When Burns & Associates called states to ask for participation in the survey, we also asked them to answer Question 1: the basis of the physician fee schedule for their Medicaid Fee-for-Service program. Responses were as follows:

▪ Oregon	Fee Schedule (which may include multiple methodologies)
▪ Michigan	RBRVS (Medicare's Resource Based Relative Value Scale)
▪ Washington	RBRVS
▪ Wisconsin	Fee schedule (which may include multiple methodologies)
▪ Iowa	RBRVS
▪ Nebraska	Relative Value Scale
▪ Indiana	Fee schedule (which may include multiple methodologies)
▪ Ohio	RBRVS
▪ Vermont	Fee schedule (which may include multiple methodologies)

Three states returned answers to some of the other questions on the survey: Nebraska, Ohio and Wisconsin. The states answered the simple questions that did not require accessing data. These questions are 1, 2, 3, 8, 9, 10 and 11. After the budget and stimulus package crises calm, some states indicated they would reply to the survey. The following summarizes the state responses to the narrative questions thus far. B&A will continue to accumulate and report on responses as they come in.

Question 2: Has the state or another entity conducted an analysis of access to care for physician services in the Fee-for-Service (FFS) program?

None of the three respondents have had independent analyses of their physician rates for access to care.

Question #3: Have providers or recipients challenged the state in court on access to physician services under the FFS program?

None of the three respondents have had their FFS rates challenged in courts for access to care reasons.

Questions #8: Has the state taken steps to improve access to physicians or physician extenders? If so, what are they?

In Nebraska, primary care providers and OB/GYNs receive enhanced reimbursement. Additionally, mid-level practitioners receive the same level of reimbursement as physicians.

Ohio increased the FFS rates for professional services in the aggregate by three percent effective in July 2008. They also "rebalanced" the rates, essentially moving dollars from CPT codes billed by the procedural providers such as radiologists and surgeons to primary care practitioners. Ohio also greatly expanded the scope of practice for Advanced Practice Nurses in 2008 and is working on similar measures for Physician Assistants.

Effective for dates of service on and after July 1, 2008, the Wisconsin Medicaid program increased the maximum reimbursement rates for most medical services by one percent as authorized by the Wisconsin state legislature in the 2007-2009 biennial budget.

Question #9: Does the state have tracking mechanisms in place for access to primary and specialty care? If so, what are they?

None of the three respondents reported have any tracking mechanisms.

Question #10: Does the state utilize any pay for performance (P4P) and quality incentives in its FFS Medicaid program? If so, what are they?

None of the respondents reported having P4P or quality incentives in place or contemplated. However, our Oregon state contact indicated in conversations with us that this type of reform is under serious discussion in their state.

Question #11: Does the state have any information on how their physician rates compare to the commercial rates? If so, what is the comparison?

None of the respondents have this information. Ohio stated that they benchmark against Medicare, which makes sense because they base their rates off of the RBRVS.

APPENDIX B

Report to the Legislature: Comparison of Payment Rates for Services Delivered by Physicians and Non-Physicians in the Medicaid Fee-for-Service Program

Deliverable #3 under CFMS Contract #B23431

February 3, 2009

BURNS & ASSOCIATES, INC.

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TABLE OF CONTENTS

SECTION I: INTRODUCTION

The Minnesota Department of Human Services (DHS), Health Services and Medical Management Division (HSMMD) retained Burns & Associates, Inc. (B&A) to evaluate the adequacy of availability of services (primary care and selected specialties) for fee-for-service members enrolled in the Minnesota Health Care Program (MHCP).

B&A is an independent health care consulting firm with a focus on state Medicaid programs. Among the firm's practice areas is the development and evaluation of programs, policies and provider rates. Under this engagement, B&A is to complete five deliverables, of which this report is *Deliverable #3: Comparison of Payment Rates for Services Delivered by Physicians and Non-Physicians in the Medicaid Fee-for-Service Program.* Other deliverables include an evaluation of the provider rates paid by the Minnesota DHS compared to other state Medicaid agencies, an examination of the availability of care to fee-for-service members, and a report on the results of physician and member surveys related to availability of care.

DHS is required to provide this report as a result of the Office of the Legislative Auditor's (OLA) February 2008 report "Financial Management of Health Care Programs[1]." In Chapter 3 of the report, "State Payment Rates for Health Care Programs," the OLA concluded that the Legislature and the DHS have not taken sufficient steps to address concerns about the adequacy and equity of Minnesota's fee-for-service rates. Specifically, the OLA recommended:

- DHS should report to the 2009 Legislature on the adequacy of Minnesota's fee-for-service provider rates. As part of this analysis, DHS should identify service areas or regions of the state in which public program enrollees have had difficulty accessing providers.

- The Legislature should consider increasing fee-for-service payment rates for certain types of providers, such as primary care physicians.

Minnesota's physicians are paid for services delivered to the fee-for-service (non-managed care) population at the lower of either:

1. Their submitted charge, or
2. The median rate established using 1989 data that is discounted 20% (for evaluation and management or OB/GYN services) or 25% (all other services)

Other than a one-time across the board increase of 3% in 2000, physicians have not received rate increases since the 1989 base year data was utilized, with one exception. Some mental health services provided by a psychiatrist received a 23.7% increase in addition to the 3% increase during this time period.

This report examines differences between payments to physicians and nonphysicians who are delivering the same service.

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[1] The OLA report can be found at: http://www.auditor.leg.state.mn.us/ped/pedrep/healthcare.pdf
The discussion of fee-for-service rates is on pages 49-53 of the report.

SECTION II: METHODOLOGY

B&A examined over 3.1 million claims (5.2 million detail lines) billed by physicians for services delivered to Medicaid fee-for-service beneficiaries during the period July 1, 2006 through June 30, 2008. Payments made to physicians for these services totaled $302 million. The majority of services provided by physicians were performed exclusively or almost exclusively by them and not other provider types. The purpose of this report is to examine the services that were billed in sufficient volume by other provider types in addition to physicians and to compare the rates paid to each provider type.

Determining the Sample of Services to Examine

Among the 8,270 service codes billed by physicians during our study period, 91 percent of them (7,520) were billed less than 500 times by physicians. These were removed from our analysis. The remaining 750 services were further examined to study if other provider types in addition to physicians billed these services. In order for a service code to be included in the analysis, all of the following criteria must be met:

- Physicians could not represent less than 50 percent of the total payments made for the service.
- Physicians could not represent more than 90 percent of the total payments made for the service.
- A specific nonphysician provider must represent at least 10 percent of the total payments made for the service.
- Both physician and nonphysician payments for the service code must equal at least $50,000 over the two-year period of claims studied.

Additionally, Minnesota's DHS, like Medicaid agencies nationwide, are constrained in the fees they can pay providers for laboratory services to the maximum rate on the Medicare Clinical Laboratory fee schedule. Because Minnesota's rates for lab services are the same across provider types, these services were removed from the analysis.

Similarly, there were three drug codes that were commonly billed by physicians and nonphysicians. The rates paid to all provider types who bill for these drugs is the same. These codes were also removed from the analysis.

Utilizing the criteria above, a net result of 21 service codes remained for analysis.

Determining the Nonphysician Provider Types to Compare Against

Once the service codes were defined, B&A examined the types of nonphysicians that billed for each service. The provider types and services billed in common with physicians are as follows:

1. Nurse Practitioners: 14 codes, primarily office visits and evaluations
2. Nurse Midwife: 4 codes, two related to delivery and two related to obstetrical care
3. Clinical Nurse Specialist: 3 codes, related to psychotherapy

Preparing the Final Dataset for Analysis

In some situations, the services identified for our analysis had a payment amount of $0 in the claims dataset. When this occurred, the details were removed before the comparative analysis was conducted.

For each service billed by both physicians and a nonphysician provider type, B&A tabulated the total number of services billed and total payments made for each service for each provider type. From this, we calculated the average payment paid per service to both provider types. In the exhibits that appear in the next section, the difference between the physician's rate and nonphysician's rate is shown.

Minnesota's DHS is not unusual among Medicaid agencies nationwide in that a payment rate is placed on file for a particular service (often called the "base rate") but there may be adjustments—both upward and downward—to the base rate in certain circumstances. These adjustments typically are a result of legislation targeting changes in payments to specific provider types or for specific services. This "special pricing" is usually not reflected in a state's published fee schedule. The base rate on file is only the starting point of the pricing calculation.

Special pricing was found in many of the services examined for this report. Examples of special pricing in Minnesota's fee-for-service system include, but are not limited to, the following:

- Pediatric services are paid a 15% upward adjustment from the base rate
- Obstetric providers receive a 26.5% upward adjustment from the base rate
- Community and public health clinics receive a 20% upward adjustment from the base rate
- Advance practice nurses receive a 10% reduction from the physician's rate
- Physicians receive a 40% downward adjustment from the base rate when the service is delivered in an outpatient hospital setting instead of in a doctor's office

As seen above, payments made to providers may differ based either on the type of provider delivering the service and/or the location where the service is delivered. An advance practice nurse, for example, could conceivably be paid more than a physician for the same service even though nurses are paid less than physicians (10% downward adjustment from base) if the nurse delivered the service in a public health clinic (20% upward adjustment from base).

Also, providers may be subject to other reductions during the pricing process for items such as third party liability, spenddown, or authorizations for the service that are limited to an amount lower than what was billed.

In order to factor in these situations, B&A analyzed the average payment made to physicians and nonphysicians for the selected services based on the location where the service was delivered. We split out for each service the most common locations where these services are delivered to fee-for-service recipients: an office setting, outpatient hospital setting, community or public health clinic setting, or any other setting. This was done to better study differences between physician and nonphysician rates that may be due to special pricing based on service location. The exhibits in Section III display only those locations where there is sufficient volume for meaningful comparisons.

SECTION III: FINDINGS

Payment rates for services delivered by physicians and the specific nursing provider types are detailed in Exhibits 1 and 2 on the next two pages. Exhibit 1 compares rates paid to physicians and nurse practitioners for office/outpatient evaluation and visits. Exhibit 2 compares physicians to nurse practitioners, clinical nurse specialists and nurse midwives for services other than office/outpatient evaluation related to physical health.

There are some meaningful differences in the average rates paid between physicians and nonphysicians for the 21 services examined. This, however, should be reviewed in the context of all payments made to these providers. For example, in our two-year dataset, these 21 codes examined represent 21 percent of the $301 million in payments made to physicians. Among nonphysicians, the total payments made were $7.5 million. Among the 21 services studied, 82 percent of the payments were made to physicians and only 18 percent to nonphysicians. Finally, among nonphysicians, 89 percent of the payments are concentrated in only 10 services. Each of these will be discussed below.

Five of the high-volume services paid to nonphysicians are for office/outpatient evaluations or visits for new or established patients (refer to the first five codes listed on Exhibit 1). For the new patient codes (CPT 99202 and 99205), nurse practitioners were paid, on average, six percent higher than physicians. For the established patient codes, nurse practitioners were paid 11 percent higher for a 10 minute visit (CPT 99212), 73 percent higher for a 15 minute visit (CPT 99213), and the same amount for a 40 minute visit (CPT 99215) when these visits are in an office setting. When the visits are in an outpatient hospital setting, the average payment to nurse practitioners is higher than physicians because of the special pricing rule that physician rates are discounted 40 percent from the published rate when the service is performed in an outpatient setting.

The other five high-volume services appear on Exhibit 2. When comparing average rates paid to physicians and clinical nurse specialists delivering the same service, the clinical nurse specialist is paid on average either two percent lower or 23 percent lower than physicians for a 20-30 minute psychotherapy session, depending upon the setting (CPT 90805). For a 45-50 minute session, the nurse is paid on average 12 percent less than the physician (CPT 90807). For pharmacological management (CPT 90862), the rate paid to the nurse may be greater or higher than the physician based upon the setting. It was found that in the office setting, the nurse was paid 20 percent less than the physician; in the outpatient hospital setting, 71 percent higher than the physician; and in other settings, about the same as the physician.

The other two high-volume services are for routine obstetrical care (CPT 59400) and vaginal delivery, including postpartum care (CPT 59410). The average rates are compared between the physicians and nurse midwives. In the case of CPT 59400, the nurse midwife on average was paid five percent more than the physician; for CPT 59410, the nurse midwife was paid three percent more than the physician.

Exhibit 1
Comparison of FFS Services Billed by Physicians and Nurse Practitioners for Office/Outpatient Evaluations and Visits, SFYs 2007-2008

CPT Code	CPT Description	Number of Services Paid to Physicians	Number of Services Paid to Nurse Practitioners	Dollars Paid to Physicians	Dollars Paid to Nurse Practitioners	Avg Rate Paid to Physicians	Avg Rate Paid to Nurse Practitioners	Percent Nurse Avg Rate is Higher/Lower than Physician Avg Rate
99202	Office/outpatient visit, new patient, 20 min							
	Office Setting	20,311	4,536	$635,549	$150,402	$31.29	$33.16	6%
99205	Office/outpatient visit, new patient, 60 min							
	Office Setting	4,232	1,907	$411,723	$197,481	$97.29	$103.56	6%
99212	Office/outpatient visit, established patient, 10 min							
	Office Setting	69,920	11,865	$1,931,813	$362,655	$27.63	$30.57	11%
	Outpatient Hospital Setting	21,859	3,024	$1,714,226	$285,632	$78.42	$94.45	20%
99213	Office/outpatient visit, established patient, 15 min							
	Office Setting	327,751	40,439	$8,924,254	$1,904,928	$27.23	$47.11	73%
	Outpatient Hospital Setting	73,495	12,118	$4,879,393	$1,249,130	$66.39	$103.08	55%
99215	Office/outpatient visit, established patient, 40 min							
	Office Setting	31,667	3,777	$2,086,254	$248,010	$65.88	$65.66	0%
	Outpatient Hospital Setting	10,606	1,925	$484,832	$100,947	$45.71	$52.44	15%
99308	Subsequent nursing facility care, 15 min with patient							
	Non-office or Hospital Setting	2,425	2,041	$87,459	$73,684	$36.07	$36.10	0%
99384	Initial comprehensive preventive medicine evaluation and management, age 12-17							
	Office Setting	2,208	1,536	$64,240	$54,515	$29.09	$35.49	22%
99392	Periodic preventive medicine reevaluation, age 1-4							
	Office Setting	17,431	2,253	$283,846	$81,572	$16.28	$36.21	122%
	Outpatient Hospital Setting	3,009	692	$144,689	$26,931	$48.09	$38.92	-19%
99394	Periodic preventive medicine reevaluation, age 12-17							
	Office Setting	7,066	2,168	$144,523	$80,343	$20.45	$37.06	81%
99396	Periodic preventive medicine reevaluation, age 40-64							
	Office Setting	8,183	1,069	$275,511	$40,107	$33.67	$37.52	11%

Exhibit 2
Comparison of FFS Services Billed by Physicians and Nurse Providers, SFYs 2007-2008

CPT Code	CPT Description	Number of Services Paid to Physicians	Number of Services Paid to Nurse Provider	Dollars Paid to Physicians	Dollars Paid to Nurse Provider	Avg Rate Paid to Physicians	Avg Rate Paid to Nurse Provider	Percent Nurse Avg Rate is Higher/Lower than Physician Avg Rate
Comparing Physician Rates to Nurse Practitioner Rates (non office/outpatient evaluation or visit)								
90471	Immunization administration, single or combination vaccine							
	Office Setting	74,615	9,854	$373,661	$61,735	$5.01	$6.26	25%
90472	Immunization administration, each additional vaccine							
	Office Setting	28,396	4,804	$249,671	$55,831	$8.79	$11.62	32%
90649	HPV vaccine							
	Office Setting	5,750	1,392	$200,814	$48,926	$34.92	$35.15	1%
99436	Attendance at delivery							
	Inpatient Hospital Setting	1,014	898	$72,933	$62,609	$71.93	$69.72	-3%
Comparing Physician Rates to Clinical Nurse Specialist Rates								
90805	Individual psychotherapy, 20-30 min, with medical evaluation and management							
	Office Setting	17,391	2,011	$1,092,792	$97,882	$62.84	$48.67	-23%
	Non-office or Hospital Setting	2,427	1,797	$155,933	$112,679	$64.25	$62.70	-2%
90807	Individual psychotherapy, 45-50 min, with medical evaluation and management							
	Office Setting	2,523	953	$286,037	$95,435	$113.37	$100.14	-12%
90862	Pharmacologic management							
	Office Setting	43,479	9,055	$2,926,943	$485,414	$67.32	$53.61	-20%
	Outpatient Hospital Setting	13,575	1,785	$637,275	$143,411	$46.94	$80.34	71%
	Any Other Setting	23,420	11,342	$1,491,563	$737,776	$63.69	$65.05	2%
Comparing Physician Rates to Nurse Midwife Rates								
59400	Routine obstetrical care							
	Any Setting	3,043	405	$2,362,612	$329,633	$776.41	$813.91	5%
59409	Vaginal delivery only							
	Inpatient Hospital Setting	1,389	193	$714,059	$88,616	$514.08	$459.15	-11%
59410	Vaginal delivery, including postpartum care							
	Inpatient Hospital Setting	1,966	268	$1,114,039	$156,721	$566.65	$584.78	3%
H1001	Prenatal care; at-risk enhanced service; antepartum management							
	Office Setting	2,408	238	$192,194	$19,023	$79.81	$79.93	0%
	Outpatient Hospital Setting	264	425	$21,890	$35,487	$82.92	$83.50	1%

SECTION IV: RECOMMENDATIONS

The volume of services and amount of payments made is low for services when both a physician and nonphysician bill for the same service. When it does occur, it is not because Minnesota's DHS has published a rate to pay the nonphysician at a higher rate. Rather, the higher rate is an artifact of special pricing considerations. These payment adjustments, developed over time as a result of various legislative requirements for particular circumstances, yield little transparency to providers with regard to what they will actually be paid. The recommendations below, therefore, are offered not just to address unintended differences in physician and nonphysician rates but also in an effort to promote better transparency of all rates paid in Minnesota's fee-for-service system.

1. The DHS should adopt the Medicare Resource-Based Relative Value Scale (RBRVS) as per Legislative mandate. Resources should be put towards implementation of this system as a base for further rate changes.

   Implemented in 1992, the Medicare RBRVS is a methodology that is based on three factors of "resource use": physician effort, practice expense and professional liability insurance. The resource use factors (called relative value units, or RVUs) for each service are multiplied by a standard "conversion factor" that is a dollar amount to produce a reimbursement rate for each service. The resource use factors for specific services are reviewed annually by a review committee (that includes the American Medical Association among other organizations) to ensure that the factors reflect current practices. The resource use factors for all services are reviewed every five years. The "conversion factor" is reviewed and may be adjusted by Medicare annually.

   The RBRVS system is a national standard of reimbursement that virtually all physicians understand, is regarded as having equitable resource use factors for the various physician services, and is relatively easy to administer. Implementation of an RBRVS system will create a base for consistency and the ability to make modifications that will be inherently more logical than the current fee-for-service rate system. If the RBRVS is adopted, Minnesota should annually update the RVUs to coincide with Medicare's changes.

2. Utilize the "conversion factor" in the RBRVS to apply policy decisions related to addressing payment differences across provider types or service locations. If the state wishes as a policy matter to differentiate between provider specialties, these goals can easily be achieved by using a different conversion factor for each provider type. Different conversion factors could also be utilized by service location. One table can be published annually to show providers in a transparent and easy-to-understand method how their payment may differ based on provider specialty and/or service location.

APPENDIX C

Report to the Legislature: Evaluation of Availability of Physician Services to Medicaid Fee-for-Service Beneficiaries

Deliverable #2 under CFMS Contract #B23431

February 22, 2009

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TABLE OF CONTENTS

LISTING OF EXHIBITS

The following exhibits are repeated in Section III.B for each of the eight regions in the state. Refer to the Table of Contents for the page in which each region begins. Exhibits are numbered the same for each region except for one digit. For example, Exhibit III.B.1(a) shows Fee-for-Service members per 1,000 in the Northwest Region, whereas Exhibit III.B.2(a) shows the same information for members in the Northeast Region.

The following exhibits are repeated in Section III.D for each of the eight regions in the state. Refer to the Table of Contents for the page in which each region begins.

EXECUTIVE SUMMARY

The Minnesota Department of Human Services (DHS), Health Services and Medical Management Division (HSMMD) retained Burns & Associates, Inc. (B&A) to evaluate the adequacy of availability of services (primary care and selected specialties) for fee-for-service (FFS) members enrolled in the Minnesota Health Care Program (MHCP). Under this engagement, B&A is to complete five deliverables, of which this report is Deliverable #2: *Evaluation of Availability of Care*. Other deliverables include an evaluation of the provider rates paid by the Minnesota DHS compared to other state Medicaid agencies, an examination of rates paid to physicians and non-physicians for delivering the same service, and a report on the results of physician and member surveys related to availability of care.

DHS is required to provide this report as a result of the Office of the Legislative Auditor's (OLA) February 2008 report "Financial Management of Health Care Programs[1]." In Chapter 3 of the report, "State Payment Rates for Health Care Programs," the OLA concluded that the Legislature and the DHS have not taken sufficient steps to address concerns about the adequacy and equity of Minnesota's fee-for-service rates. Specifically, the OLA recommended:

- DHS should report to the 2009 Legislature on the adequacy of Minnesota's fee-for-service provider rates. As part of this analysis, DHS should identify service areas or regions of the state in which public program enrollees have had difficulty accessing providers.

- The Legislature should consider increasing fee-for-service payment rates for certain types of providers, such as primary care physicians.

This report examines availability at the statewide level, region level, and county level for the FFS program only. The provider specialties examined include:

- Primary Care providers, shown in Sections III.A (statewide) and III.B (by region) of the report

- Specialists including OB/GYNs, psychiatrists, dentists, cardiologists, neurologists and orthopedic surgeons, shown in Sections III.C (statewide) and III.D of the report

Findings Related to Primary Care

The 8,967 in-state Primary Care providers in this study were categorized as Active, Limited or Inactive based upon the number of services (claims) they billed the state for FFS members during State Fiscal Years 2007 and 2008. Since physicians who participate in the State's employee benefit program must also agree to participate in the Medicaid FFS program, distinctions can be made between those who actively seek Medicaid FFS members as patients and those who see members more on an ad hoc basis. The designation of Active, Limited and Inactive was created to measure the potential availability that members may have in their region against the more realistic measure of availability to actively-participating providers.

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[1] The OLA report can be found at: http://www.auditor.leg.state.mn.us/ped/pedrep/healthcare.pdf
The discussion of fee-for-service rates is on pages 49-53 of the report.

There are other primary care providers who do not serve FFS members but do participate in the Medicaid managed care program. It is important to recognize these providers as another potential source that FFS members may have in their region if the managed care providers agreed to participate in the FFS program.

Each county was designated as "Low Availability", "Medium Availability", "High Availability" or "No Availability" based upon the ratio of FFS members in the county to the number of providers in the county. "No Availability" means that there is no provider in the county. This method of categorization should be noted for its limitations in that members are free to access providers outside of their home county. For counties that border other states, members may even access providers in other states if those providers agree to participate in Minnesota's Medicaid FFS program.

It was found that there is sufficient availability in all of the larger cities in the state when only Active FFS primary care providers are considered, but there is no availability in five rural counties and low availability in ten other rural counties. If all FFS providers are considered (including Limited and Inactive providers), the number of low availability counties is reduced to two (Benton and Dodge). There is no improvement in availability of these counties if primary care providers in the Medicaid managed care program are also considered. However, including the managed care providers improves availability in other counties. Of Minnesota's 87 counties, those with high availability of primary care increase from 27 to 57 when changing from Active-only FFS providers to All FFS providers. When managed care providers are included in the calculation, the high availability counties increase to 65.

Findings Related to Specialist Care

From an urban/rural perspective, in general there is sufficient availability for each of the specialist types studied in the urban areas of the state and limited to no availability in the rural regions. The one exception is for dentists where availability is spread evenly among most counties and only three counties do not have dentists available to FFS members.

B&A examined the cities with populations greater than 60,000 citizens based on the latest census data available. The table on the next page summarizes our findings related to availability to specialists in urban regions of the state.

		Level of Availability to Each Specialist in the Urban Area					
City/Cities	**County**	**OB/GYN**	**Psych.**	**Dentist**	**Cardiology**	**Neurology**	**Ortho**
Duluth	St. Louis	Medium	Medium	Medium	High	High	High
St. Cloud	Stearns	Medium	Medium	Medium	High	High	High
Rochester	Olmstead	High	High	Medium	High	High	High
Coon Rapids	Anoka	Medium	Medium	Medium	Medium	Medium	Medium
Twin Cities*	Hennepin, Ramsey, Dakota	Medium	Medium	Medium	Medium to High	Medium to High	Medium to High

*Includes Bloomington, Brooklyn Park, Burnsville, Minneapolis, Eagan, Plymouth, St. Paul

Conversely, availability pf care is low to nonexistent in rural areas of the state (table below excludes the seven counties listed above).

Specialist Type	Counties with Availability	Counties with Low Availability	Counties with No Availability
OB/GYN	34	6	40
Psychiatrist	18	20	42
Dentist	67	10	3
Cardiologist	4	1	75
Neurologist	4	9	67
Orthopedic Surgeon	29	6	45

Correlation Between Availability and Utilization

In most regions of the state, it was found that limited availability could result, but did not always result, in lower utilization of services. Specifically, counties designated as having low availability for FFS members to primary care providers often had lower primary office visit utilization (measured on a per 1,000 member basis) than the statewide average but these same counties had lower ER utilization per 1,000 as well. This suggests that potentially lower availability does not equate to lower access to care. Conversely, counties with potentially higher availability did not always yield higher office visit utilization. Many examples were found at the county level where the presence of what appeared to be sufficient availability to providers did not correlate to increased utilization.

In many counties in the Northeast, Northwest and Southeast Regions of the state, services billed by primary care providers for services performed in the ER were higher than other regions of the state. This could be due to the limited availability of primary care services in many counties in these regions.

There are many counties and, in some cases entire regions of the state, where the availability of certain specialists is extremely limited. As a result, utilization for specialty care varies widely across counties. B&A controlled for the wide variation in enrollment in the FFS program in each county by measuring the utilization per 1,000 FFS members across counties. Even when controlled for population size, wide variances were found, in particular for OB/GYNs, psychiatrists, cardiologists, neurologists and orthopedic surgeons. There were instances where FFS members had relatively high utilization in counties where the specialist was not even available. We conclude from this that FFS members may often travel long distances in pursuit of the care they need where it is available, usually in the urban centers of the state.

Recommendations

This report is one of many that B&A is completing for the Minnesota DHS. Another report already completed showed that physician rates in Minnesota's FFS program are considerably lower than other states. Rate increases alone may not yield improved availability of services for members. A survey of physicians and members in areas of the state that are underserved will yield more feedback as to why availability may be limited. These surveys will be in the field throughout the month of March. While awaiting the results from these surveys, the following recommendations are made for consideration to complement other recommendations previously made in this study.

1. The FFS population is proportionally higher in rural areas of the state. Likewise, availability of both primary care services as well as specialists that are used considerably by the FFS population is weaker in the rural areas. Although an increase is merited to physician rates across-the-board, consideration should be given to providing an upward adjustment (e.g. 10%-20% increase above the base rate) for physicians in rural areas to incentivize participation.

2. In light of current economic conditions and budget restrictions, the highest priority should be given to increasing the rates for evaluation and management services in the office setting to both encourage participation among primary care physicians as well as to reduce inappropriate ER usage.

3. The findings from this study showed that availability among "active" FFS primary care providers is problematic. When all potential FFS providers are considered, many of the availability problems were removed. The results of the provider survey should be studied to determine if there are factors other than reimbursement rate that are limiting providers' participation in the FFS program that can be addressed to increase participation. A final recommendation cannot be made until this information is obtained. The report of survey findings is scheduled to be delivered April 15, 2009.

4. Among the highest priority for rate increases in addition to primary care office visit services is office visit services provided by OB/GYNs and psychiatrists. If it is found that there are not enough providers even present in some rural counties to offer the services, consideration should be given to increase reimbursement to providers outside the regions to provide services there on a limited basis (e.g. twice per month). If this is done, the rate paid to these out-of-region providers needs to consider the time incurred by the providers to travel to and from the specific region that they will serve on a part-time basis.

5. Specific outreach should be made to Medicaid managed care providers who do not participate in the FFS program to determine what would incentivize them to participate in the FFS program as well.

SECTION I: INTRODUCTION

The Minnesota Department of Human Services (DHS), Health Services and Medical Management Division (HSMMD) retained Burns & Associates, Inc. (B&A) to evaluate the adequacy of availability of services (primary care and selected specialties) for fee-for-service members enrolled in the Minnesota Health Care Program (MHCP).

B&A is an independent health care consulting firm with a focus on state Medicaid programs. Among the firm's practice areas is the development and evaluation of programs, policies and provider rates. Under this engagement, B&A is to complete five deliverables, of which this report is Deliverable #2: *Evaluation of Availability of Care*. Other deliverables include an evaluation of the provider rates paid by the Minnesota DHS compared to other state Medicaid agencies, an examination of rates paid to physicians and non-physicians for delivering the same service, and a report on the results of physician and member surveys related to availability of care. Each of these reports will be synthesized into a final report delivered in May, 2009.

DHS is required to provide this report as a result of the Office of the Legislative Auditor's (OLA) February 2008 report "Financial Management of Health Care Programs[2]." In Chapter 3 of the report, "State Payment Rates for Health Care Programs," the OLA concluded that the Legislature and the DHS have not taken sufficient steps to address concerns about the adequacy and equity of Minnesota's fee-for-service rates. Specifically, the OLA recommended:

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Minnesota's physicians are paid for services delivered to the fee-for-service (non-managed care) population at the lower of either:

1. Their submitted charge, or
2. The median rate established using 1989 data that is discounted 20% (for evaluation and management or OB/GYN services) or 25% (all other services)

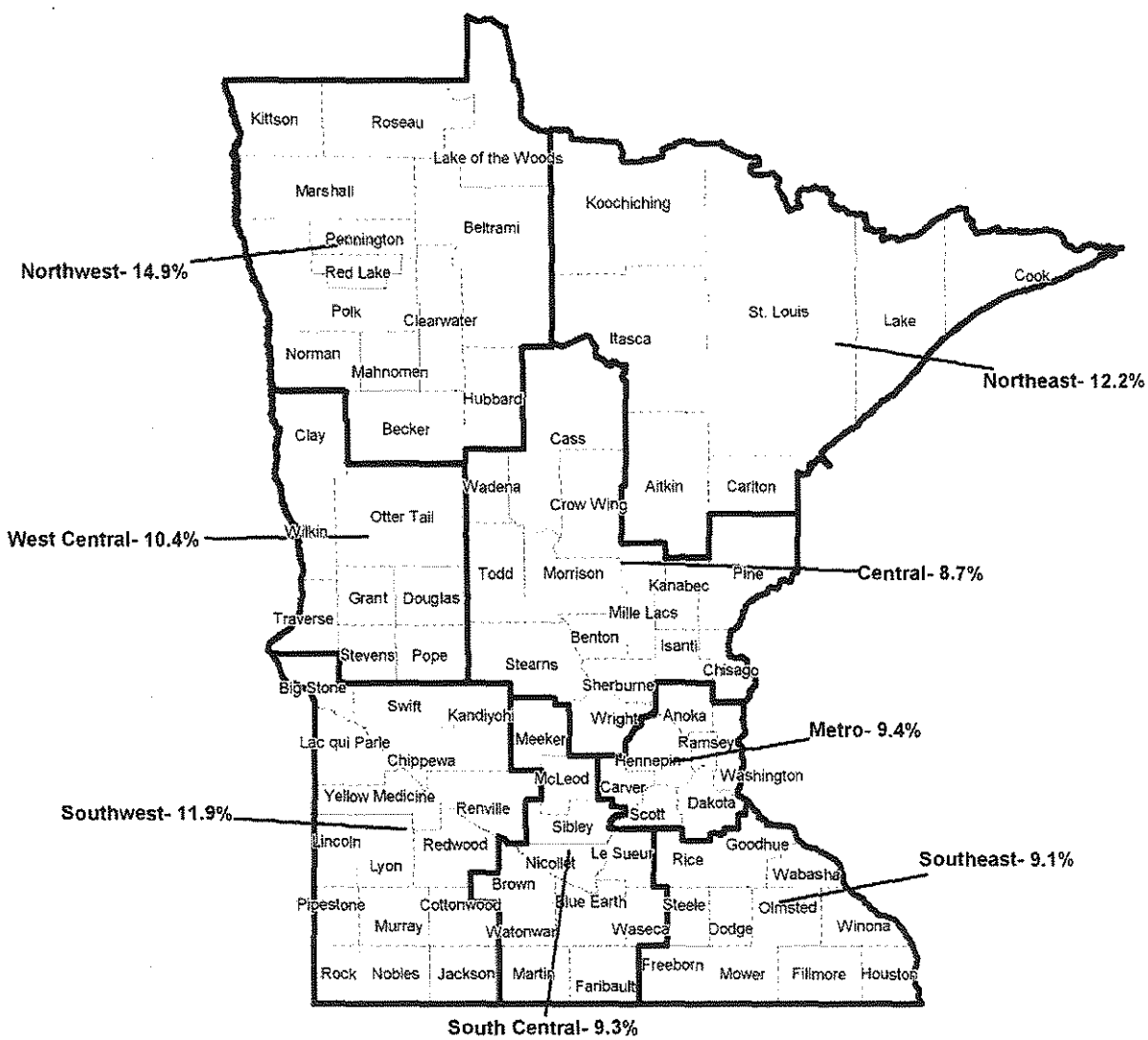
Other than a one-time across the board increase of 3% in 2000, physicians have not received rate increases since the 1989 base year data was utilized, with one exception. Some mental health services provided by a psychiatrist received a 23.7% increase in addition to the 3% increase during this time period.

This report examines availability at the statewide level, region level, and county level. For analysis and reporting purposes, the DHS has divided the state into eight regions. B&A has adopted these region designations throughout this report. The percentages shown in Exhibit I.1 on the next page reflect the percentage of the total region's population that is enrolled in the

[2] The OLA report can be found at: http://www.auditor.leg.state.mn.us/ped/pedrep/healthcare.pdf
The discussion of fee-for-service rates is on pages 49-53 of the report.

State's Medical Assistance program[3]. It should be noted that these percentages reflect enrollment in both the managed care and fee-for-service portion of the Medical Assistance program.

Exhibit I.1
Minnesota Department of Human Services' Defined Regions and Percent of the Population Enrolled in the Medical Assistance Program (Fiscal Year 2007)



This report focuses solely on the fee-for-service population. Enrollment by region for fee-for-service only members appears in Section III.

The DHS is obligated to ensure that access to services for Medical Assistance enrollees is the same or better than what is offered in the private sector. Therefore, it is important to understand

[3] Minnesota Department of Human Services' Minnesota Health Care Markets Chartbook, Section 5. http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section5.pdf

the context of the availability of physicians in the state as a whole. The U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) tracks Health Professional Shortage Areas (HPSAs). The HPSAs may be entire counties, contiguous counties or specific census tracts within counties. HRSA defines HPSAs for Primary Medical Care if the following three criteria are met[4]:

1. The area is a rational area for the delivery of primary medical care services.

2. One of the following conditions prevails within the area:
   (a) The area has a population to full-time-equivalent primary care physician ratio of at least 3,500:1.
   (b) The area has a population to full-time-equivalent primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and has unusually high needs for primary care services or insufficient capacity of existing primary care providers.

3. Primary medical care professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration.

Exhibit I.2 on the next page displays the Minnesota counties where the HRSA has determined that HPSAs are present. It may be that for some counties there are only portions of the county deemed an HPSA.

Because there are only 33 of Minnesota's 87 counties that are not fully or partially deemed as HPSAs, this report examines potential availability concerns to the Medical Assistance fee-for-service population in light of the fact that access issues may be out of the DHS's control due to the limited number of total physicians available in the state.

The remainder of this report is organized as follows:

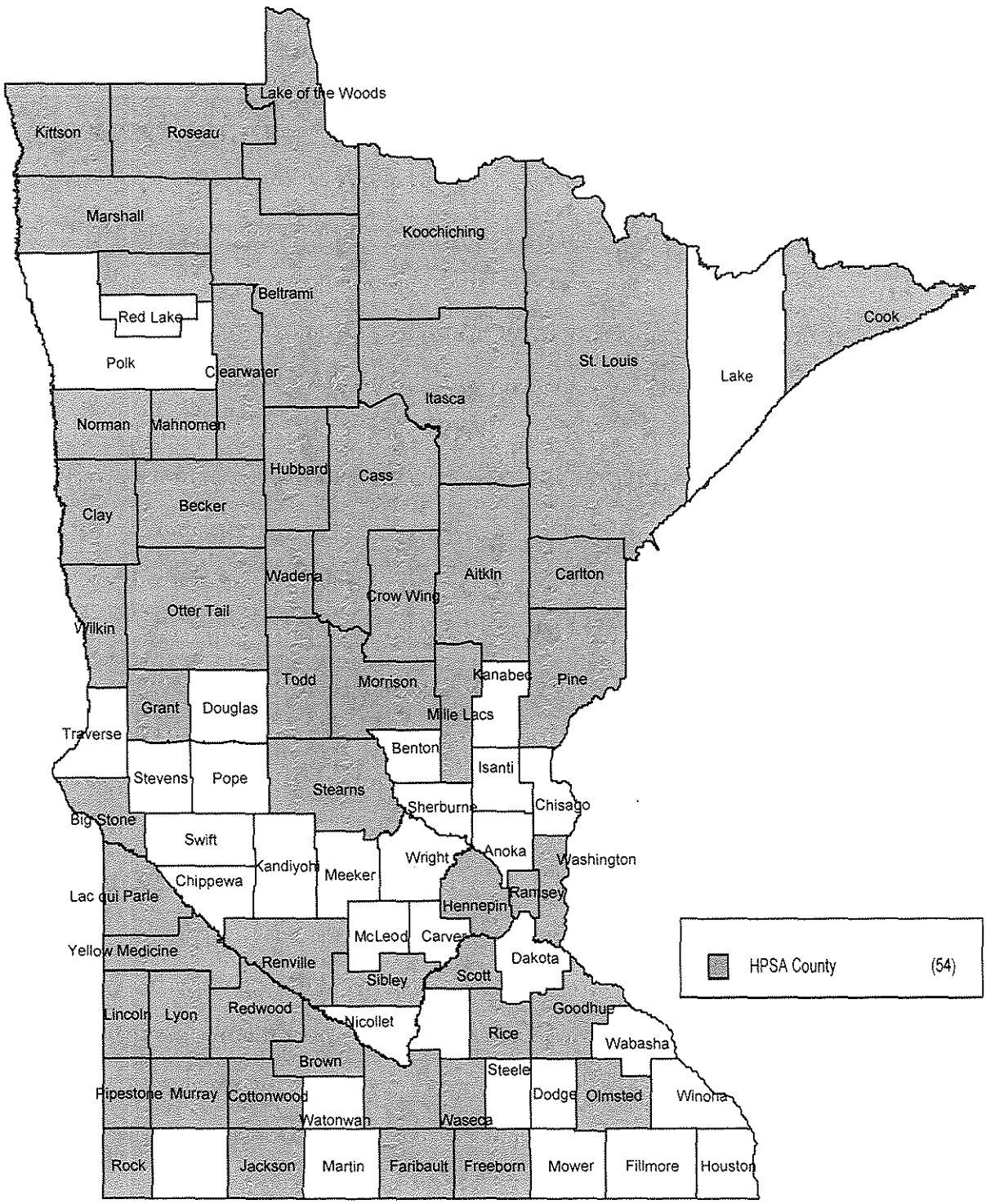
- Section II describes the methodology for selecting the members and providers used to measure availability of services

- Section III is divided into four subsections
  - Section III.A examines availability of primary care at the statewide level
  - Section III.B examines availability of primary care at eight regional levels
  - Section III.C examines availability of five physician specialties as well as dentists at the statewide level
  - Section III.D examines availability of the specialists at the regional levels

- Section IV offers recommendations to the State in light of the findings

[4] http://bhpr.hrsa.gov/Shortage/hpsacritpcm.htm

Exhibit I.2
Minnesota Counties with Primary Care Shortage Areas as defined by the U.S. Dept. of Health and Human Services' Health Resources and Services Administration



SECTION II: METHODOLOGY

In order to map recipients and providers by geographic area, it is necessary to first define the population that is considered in this analysis. Burns & Associates (B&A) evaluated data received from the state that provided information on both recipients and providers.

Determining the Recipient Population

Enrollment information was obtained from the HSMMD for the State Fiscal Years (SFY) 2007 and 2008 (July 1, 2006 – June 30, 2008). B&A limited the recipients to consider for this report as those who had been enrolled for at least one month in the fee-for-service (FFS) program during this 24-month period and who were living as of June 30, 2008. A total of 848,502 recipients fit this criteria and were further examined.

Monthly enrollment status in FFS was examined in more detail because many enrollees who ultimately enroll in the managed care portion of the Medical Assistance program spend a brief period (e.g. their first month) in the FFS program upon acceptance of eligibility. Therefore, B&A examined the length of consecutive months that each of the 848,502 recipients was enrolled in the FFS program. Although nearly 12% of recipients were enrolled in FFS during the entire two year period examined, others entered and exited FFS multiple times. Nearly one-third of all FFS recipients exited and then re-entered at least once in the two years. Though movement in and out of the FFS program is common, the average time spent in the program was about five consecutive months.

For the analysis in this report, B&A excluded FFS members who were never enrolled in the program for at least three consecutive months. These short-term recipients have little history with the program and do not have sufficient time to receive needed services while enrolled. The net result was to consider 483,353 members. The demographics of these members were compared to the entire enrollment file. No significant differences were found between the two groups.

The current county of residence was provided for each member on the enrollment file. This information was used to map FFS members in this report. Patient location is based on information current (as of December 2008) and may not correspond to the county of residence when services were received. An additional 10,077 members were excluded from the analysis due to the fact that they do not currently reside in Minnesota. The final result is 473,276 members included in the analysis.

It should be noted that due to the movement in and out of the FFS program, the total members considered does not represent the FFS population in any given month. For example, in the month of July 2006 there were 242,358 people enrolled in the FFS program. By the end of our analyses period (June 2008), there were 258,493 enrolled.

Exhibit II.1 on the next page provides a profile of the members analyzed in this study.

Exhibit II.1
Profile of the Fee-for-Service Members Studied in this Report

Region	Total Sample	Female	Male	Children (Age 18 and under)	Adults
Northwest	34,398	18,553	15,845	13,566	20,832
Northeast	35,862	19,425	16,437	10,019	25,843
West Central	16,289	9,336	6,953	5,161	11,128
Central	62,446	35,208	27,238	23,251	39,195
Metro	236,314	132,552	103,762	82,653	153,661
Southwest	21,456	12,298	9,158	8,102	13,354
South Central	25,661	14,642	11,019	9,220	16,441
Southeast	40,850	23,929	16,291	14,446	26,404
Total State	**473,276**	**265,943**	**207,333**	**166,418**	**306,858**
		56%	**44%**	**35%**	**65%**

Like most Medicaid programs that have a managed care component, Minnesota's FFS population is disproportionately comprised of adults and female members. The FFS program is concentrated among the aged, blind and disabled populations whereas the managed care program is concentrated among children and their families (including pregnant women).

Determining the Provider Population

Provider information was provided by HSMMD to B&A that included the address, practice type and specialty code for each provider on record. This information was used to identify the population of Minnesota providers that serve FFS enrollees. Among a total of 110,430 providers, B&A focused on primary care providers and select physician specialties that were also analyzed in our other deliverables in this engagement. A total of 16,885 providers were considered, which were comprised of the following specialties:

Exhibit II.2
Profile of the Fee-for-Service Providers Studied in this Report

Specialty	Total Sample	Physicians	Non-Physicians	Percent Physician	In-State Providers	Border State Providers	Percent In-State
Primary Care	10,856	8,787	2,069	81%	8,967	1,889	83%
OB/GYN	966	796	170	82%	801	165	83%
Psychiatrist	881	879	2	100%	704	177	80%
Dentist	2,061	2	2,059	0%	2,018	43	98%
Cardiologist	698	696	2	100%	476	222	68%
Neurologist	660	651	9	99%	526	134	80%
Orthopedic Surgeon	763	739	24	97%	629	134	82%
Total State	**16,885**	**12,550**	**4,335**	**74%**	**14,121**	**2,764**	**84%**

Providers often report multiple specialties to the State. Each of the specialty codes (up to five could be assigned) were examined for each provider and used to group providers into the mutually exclusive categories shown in Exhibit II.2.

There are 16 percent of the providers we considered that do not reside in the State of Minnesota even though they provide services to Minnesota FFS enrollees. Because our analysis focuses on the counties and regions within Minnesota, the out-of-state providers are excluded. However, the utilization of out-of-state providers will be considered when examining counties that border other states.

About one in five Primary Care providers are non-physicians. These are almost all nurse practitioners. B&A included these as well as slightly more than 100 other practitioners that may provide primary care services to FFS enrollees. These additional providers were tagged as Primary Care because they indicated specialties that included both primary care and specialty care. In addition to nurse practitioners, other providers in this group are:

Physician assistants	Nutrition professionals
Certified registered nurse anesthetists	Optometrists
Clinical nurse specialists	Podiatrists
Nurse midwife	Chiropractors
Public health nursing organizations	

Physicians categorized as Primary Care include general practitioners, internal medicine, preventive medicine, pediatrics, and geriatrics.

Indian Health Facilities are a specific provider designation in the file provided to B&A. Although primary care is delivered at these facilities, the Indian Health Facilities are excluded from this analysis. Although this affects most counties in Minnesota to some degree, it means that findings cannot be concluded for Red Lake County in particular.

Measuring Utilization of Services

Because Primary Care providers are the focus for most of our analysis, B&A stratified this provider group based on the number of monthly claims they submitted. Provider enrollment data from the HSMMD was used to determine the number of months that each provider was enrolled with the FFS program during SFY 2007 and SFY 2008. B&A tabulated the total number of claims each provider billed to Medicaid FFS during the two-year period. The average number of claims per month was calculated for each provider by divided their total claims billed by the number of months they were enrolled in the FFS program. Providers were then categorized based on their average. One of three categories was used to describe each provider. The definitions and number of in-state Primary Care providers corresponding with each group is as follows:

Active Primary Providers	More than 3 claims on average per month	4,899
Limited Primary Providers	Between 1 and 3 claims on average per month	1,469
Inactive Primary Providers	No more than 1 claim on average per month	2,599
		8,967

It is important to differentiate between active, limited, and inactive providers in order to best determine availability of providers. Analysis of all Primary Care providers in our sample versus only the Active Primary Care providers is included in this report. Services billed by the specialists named in Exhibit II.2 were also examined. However, B&A did not differentiate the specialists between active, limited, and inactive since the need for specialists is not at the same level as it is for Primary Care providers.

Services were also tied to each of the members for the two-year period studied. In the Findings section of the report, analyses are shown measuring the utilization per 1,000 FFS members for each provider type within a specific region of the state. It should be noted that although results are shown for utilization of services per 1,000 FFS members in the county, we included services delivered to members from providers outside of the county in which they live.

Services delivered for primary care services were further segmented into four categories for additional analysis. This was determined by the presence of procedure (CPT) codes on the claims billed by providers. Four categories were defined and are hierarchical in nature so that claims were categorized only once if criteria were met for more than one category. The categories and how they were defined are as follows:

1. Services performed by the provider in an office setting. This includes visits for new and established patients as well as consultations and medication management. [CPT codes 99201-99215, 99241-99245 and 90862]

2. Evaluation and management of a patient in the hospital setting (other than emergency room). This includes observation care. [CPT codes 99217-99239 and 99251-99255]

3. Evaluation and management of a patient in the emergency room. [CPT codes 99281-99288]

4. All other services except laboratory, medical supplies and pharmacy. This includes services that may be administered by a provider in the office or as a professional service completed in a hospital setting other than those stated above. If a provider billed for only a lab test, a medical supply (HCPCS codes), or a drug (J-codes) on a claim, the claim was excluded from our analysis.

SECTION III: FINDINGS

Section III examines current and available availability for Medicaid fee-for-service (FFS) members to primary care services and selected specialty services. This analysis is completed at the statewide level, regional level and county level. FFS members' utilization of services from each provider type were studied during State Fiscal Years 2007 and 2008 to determine if the level of a member's availability of care ultimately has an impact on the services they receive.

It is important to note that the level of availability for FFS members varies across the state due to the percentage of the population actually enrolled in the Medical Assistance FFS program. Exhibit III.A.1 on the following page shows the FFS membership in July 2007 per 1,000 citizens using the most recent available census estimate (July 2007)[5]. Many of the counties with the highest concentration of FFS members (on a per 1,000 basis) are in the northern counties whereas FFS membership is less prominent in the Metro Region and the Southeast Region. This follows the finding shown in Exhibit I.1 where a higher percentage of Minnesota's population in the Northwest and Northeast Regions was enrolled in the Medical Assistance program (FFS and managed care).

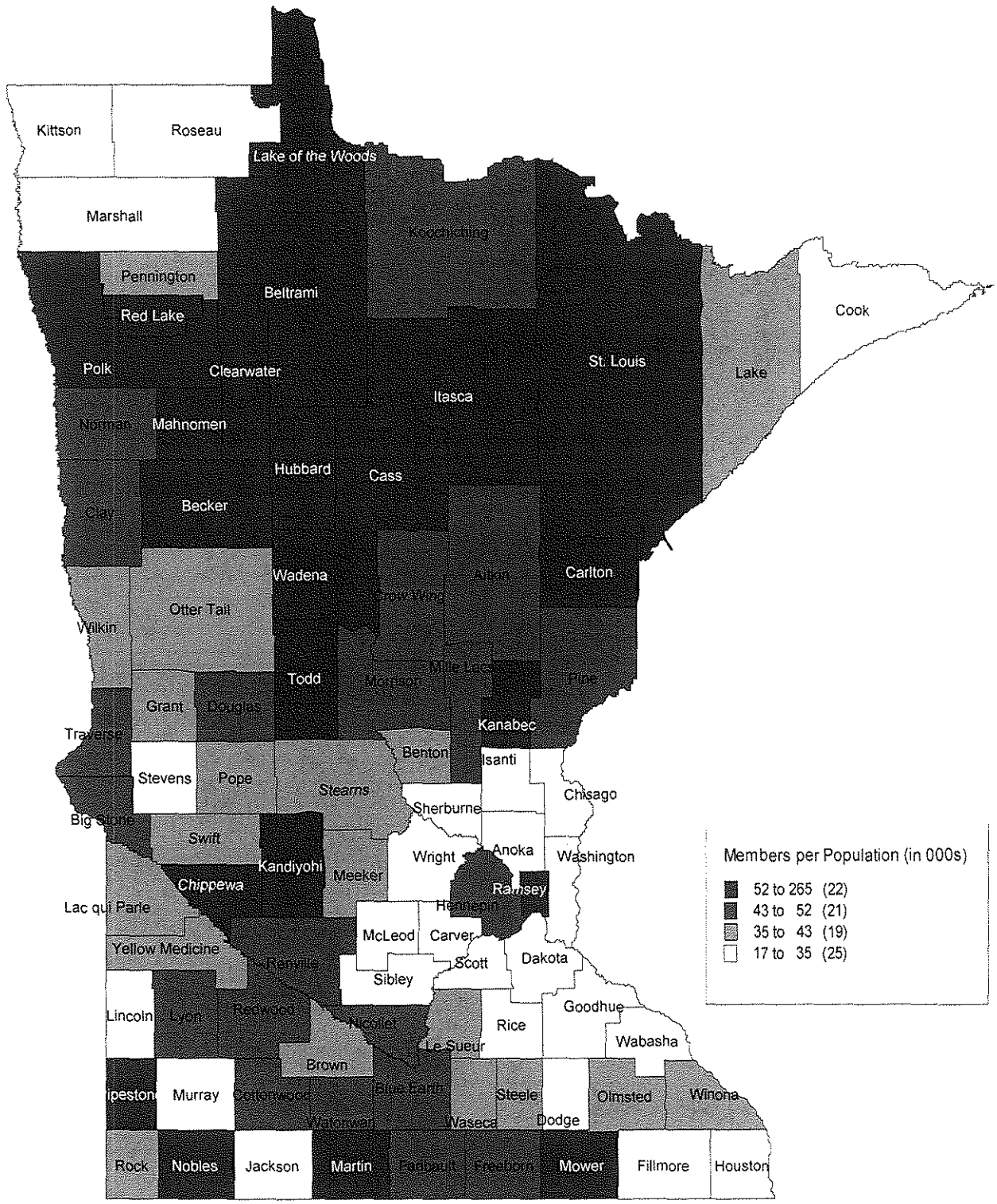
Throughout this section of the report, Burns & Associates (B&A) plotted the FFS members in our study to their zip code of residence. Note that the FFS members in this study include not just those included in Exhibit III.A.1 but any individual enrolled for at least three consecutive months in the program during the 24-month period of July 2006 to June 2008. Providers were also plotted by zip code to identify if the concentrations of provider locations in each region resemble the concentrations of members.

Section III is divided into four subsections:

- Section III.A examines availability of primary care, by county, when different provider populations are considered.
- Section III.B includes eight sections—one for each region—that each contain the same analysis in each but specific to the region. Primary care providers are identified based on their level of participation in the FFS program (active, limited, inactive). Members and primary care providers are plotted on maps. Utilization of primary care at the county level and the type/setting of services delivered by primary care providers in each county (e.g. office visits, ER, in-hospital visits, other) is also examined.
- Section III.C examines availability of five physician specialties as well as dentists at the statewide level.
- Section III.D is like Section III.B in that it has one section for each region. Each subsection examines the same data for the specialists in our study.

[5] http://www.census.gov/popest/counties/CO-EST2007-01.html

Exhibit III.1
Fee-for-Service Members (July 2007) per 1,000 Census Population, By County



Section III.A: Statewide Results for Primary Care

The 8,967 in-state Primary Care providers in this study were categorized as Active, Limited or Inactive based upon the number of services (claims) they billed the state for FFS members during SFYs 2007 and 2008. Since physicians who participate in the State's employee benefit program must also agree to participate in the Medicaid FFS program, distinctions can be made between those who actively seek Medicaid FFS members as patients and those who see members more on an ad hoc basis. The designation of Active, Limited and Inactive was created to measure the potential availability that members may have in their region against the more realistic measure of availability of actively-participating providers.

All of the physicians designated as Active, Limited or Inactive in our study had at least some experience with the FFS program in the last two years. There are other primary care providers who do not serve FFS members but do participate in the Medicaid managed care program. It is important to recognize these providers as another potential source that FFS members may have in their region if the managed care providers agreed to participate in the FFS program.

Exhibits III.A.1. III.A.2 and III.A.3 shown on the following pages measure the level of availability of primary care that FFS members have in their county under three scenarios. Each county is assigned a designation of "low availability", "medium availability", "high availability" or "no availability" (no providers) by calculating the number of FFS members in the county by the number of providers in the county. The number of primary care providers used in the calculation differs in each exhibit, while the number of members remains constant.

- Exhibit III.A.1 includes only the Active FFS primary care providers in the calculation.
- Exhibit III.A.2 includes All FFS primary care providers (Active, Limited and Inactive) in the calculation.
- Exhibit III.A.3 includes all the FFS primary care providers as well as all of the Medicaid managed care primary care providers in the calculation.

Exhibit III.A.1 shows that there is sufficient availability in all of the larger cities in the state when only Active FFS providers are considered, but there is no availability in four counties (Red Lake County is excluded from the analysis) and low availability in ten other rural counties. If all FFS providers are considered (Exhibit III.A.2), the number of low availability counties is reduced to two (Benton and Dodge). There is no improvement for these counties if primary care providers in the managed care program are also considered (Exhibit III.A.3). However, including the managed care providers improves overall availability. Counties with high availability increase from 27 to 57 when changing from Active-only FFS providers to All FFS providers. When managed care providers are included, the high availability counties increase to 65. Section III.B examines the levels of availability by county in more detail.

Exhibit III.A.1
Fee-for-Service Members per Active FFS Primary Care Provider, By County

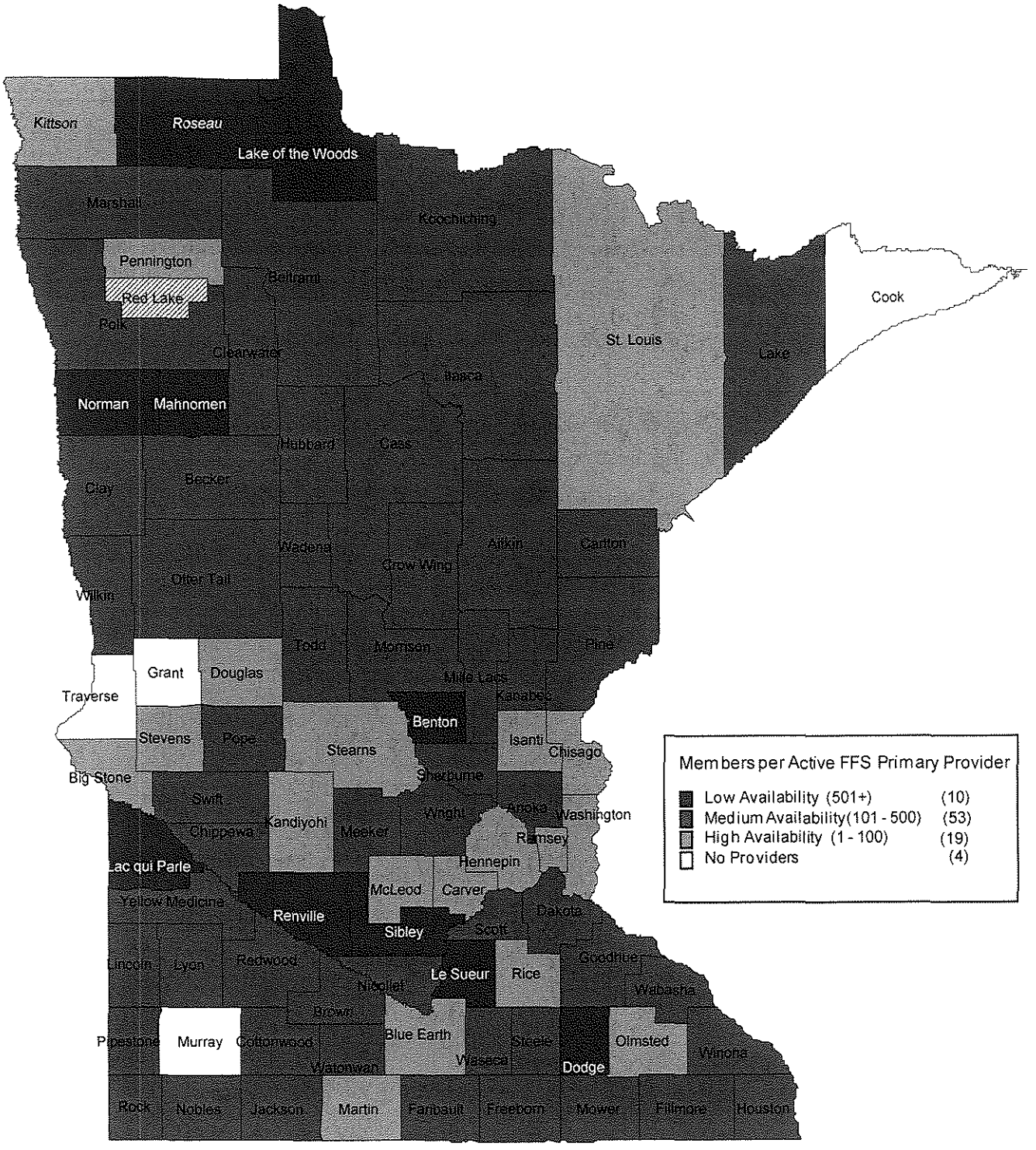


Exhibit III.A.2
Fee-for-Service Members per All FFS Primary Care Providers, By County

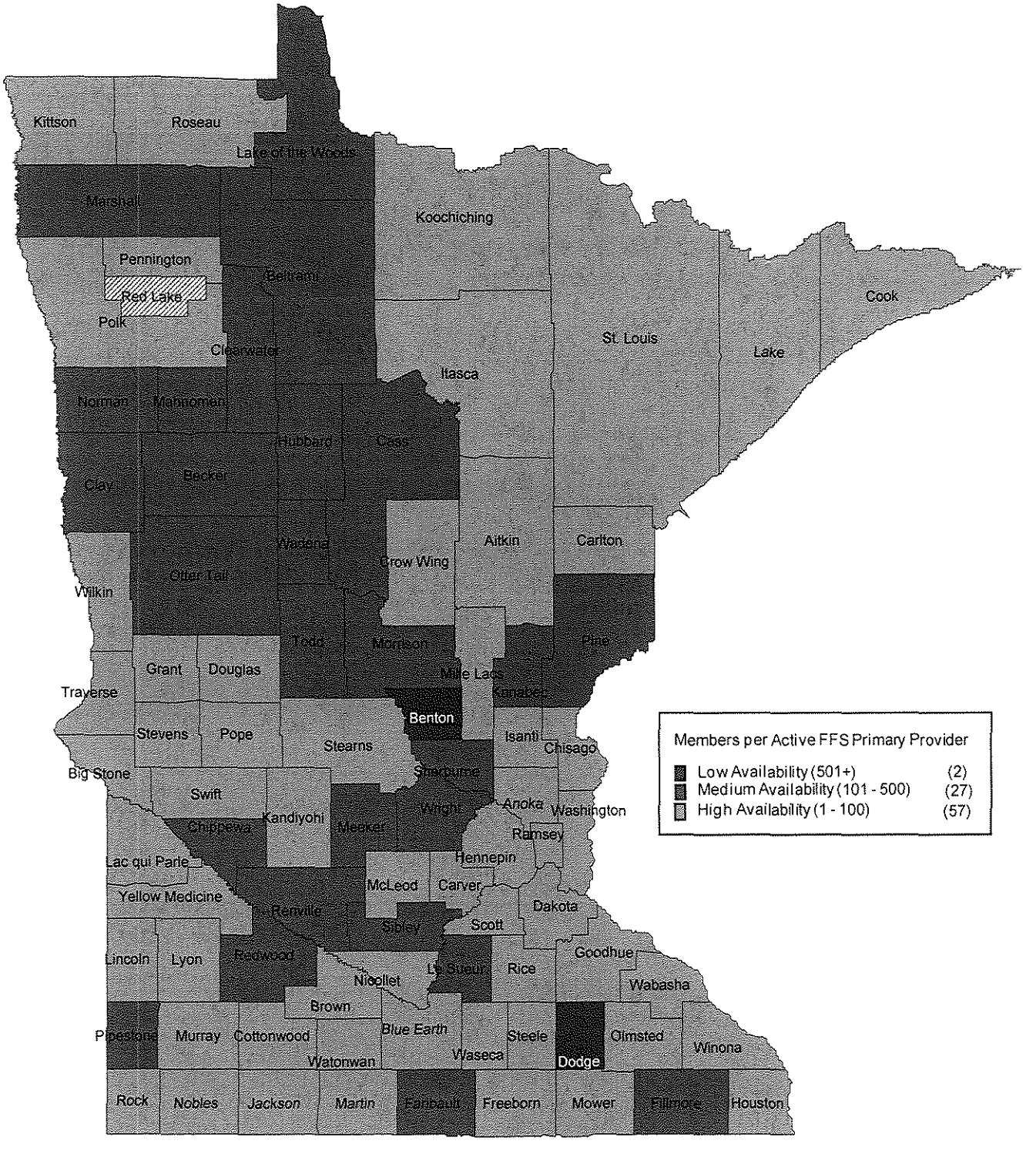
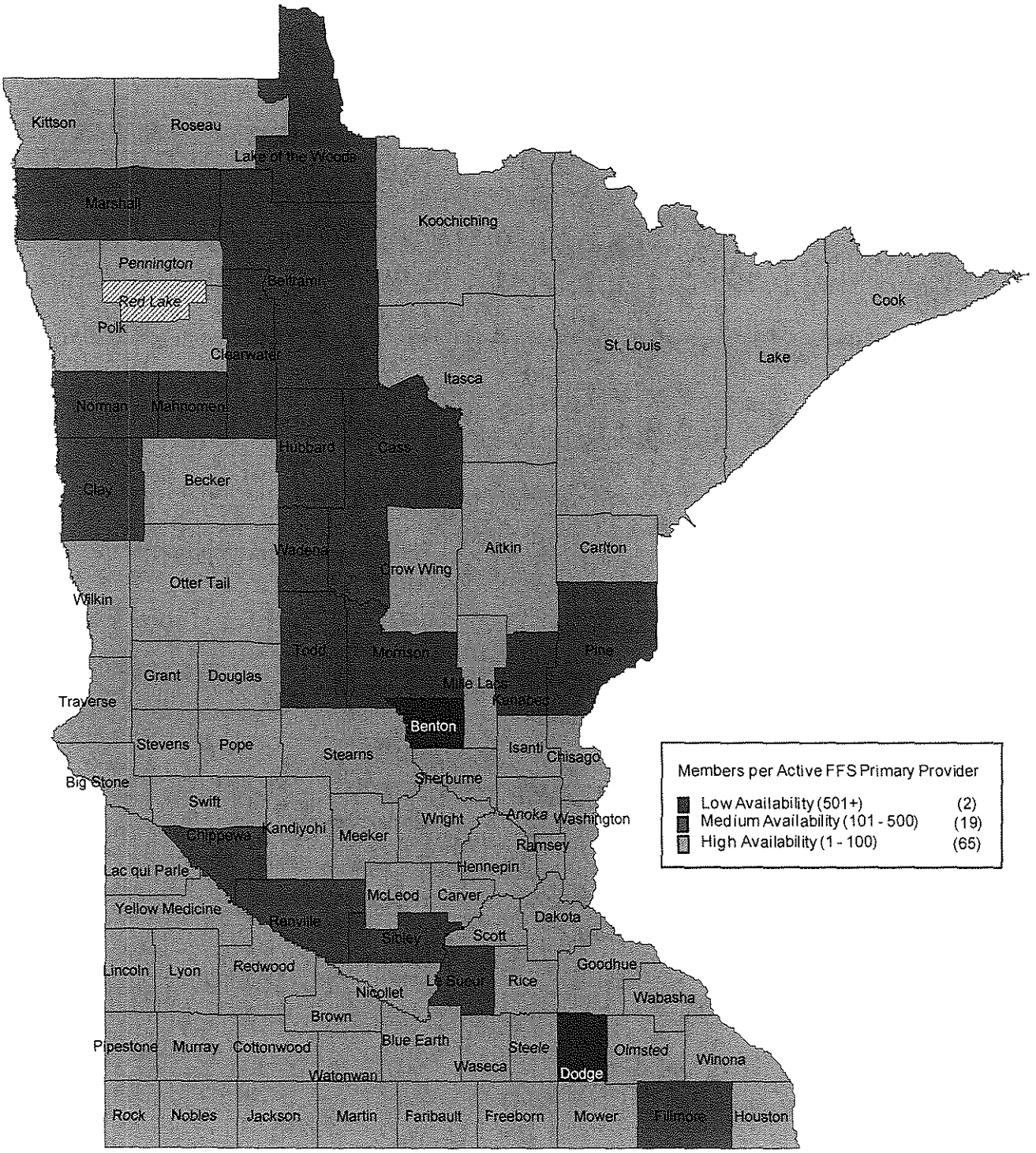


Exhibit III.A.3
Fee-for-Service Members per All FFS and Managed Care Primary Care Providers, By County

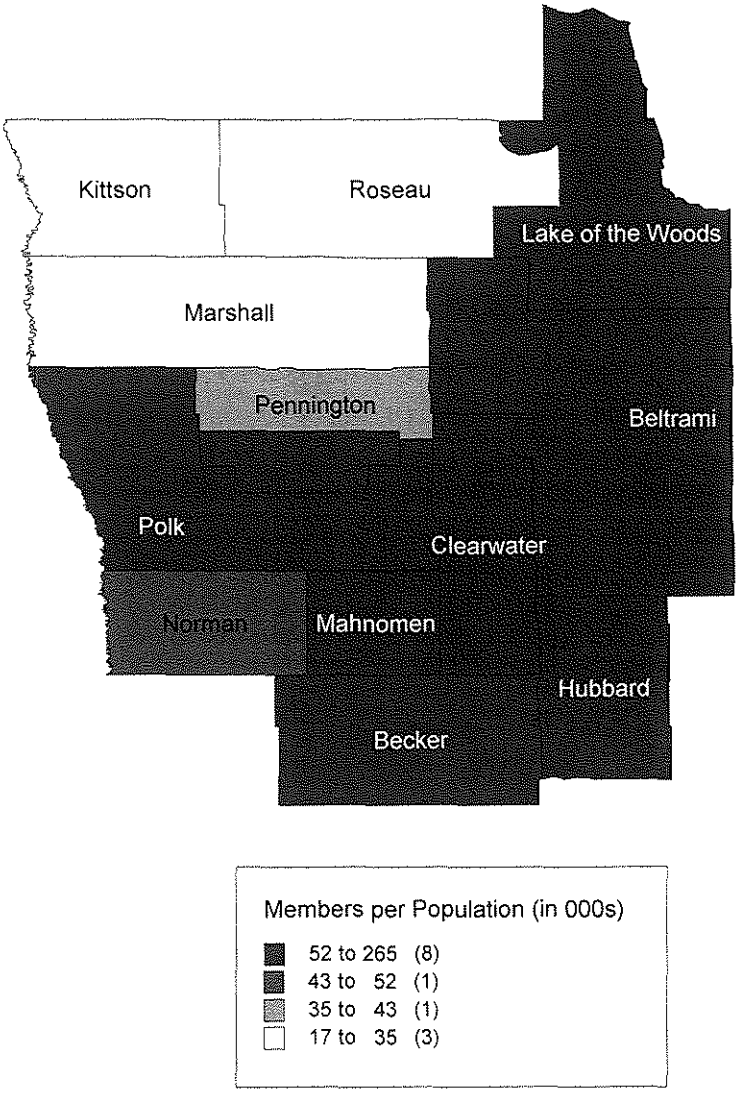


Section III.B: Results for Primary Care by Region

Northwest Region

The Northwest Region is comprised of 13 counties and represents 3.8% of the total state population. Medicaid FFS enrollment is disproportionately high at 7.3% of the total state FFS population in our sample. This is evidenced in Exhibit III.B.1(a) which shows that eight of the 13 counties in the region have FFS enrollment in the upper quartile of all counties in the state.

Exhibit III.B.1(a)
July 2007 FFS Members per July 2007 Census Estimate



The Northwest Region has only 2.8% of the FFS primary care providers (251 total). However, the percentage of these providers that are active is higher than the statewide average.

Exhibit III.B.1(b)
Medicaid FFS Primary Care Provider Base in the Northwest Region

	Active	Limited	Inactive	Total
Northwest Providers	168	23	60	251
Percent of Total	67%	9%	24%	100%
Distribution Statewide	55%	16%	29%	100%

Exhibit III.B.1(c) below plots the actual location of FFS members in the Northwest Region based upon their home zip code. This map can be contrasted with the exhibits on the next page which plot where Active FFS Primary Care providers (Exhibit III.B.1(d)) and All FFS Primary Care providers (Exhibit III.B.1(e)) are located in the region.

The exhibits on the next page illustrate that there are providers in the upper counties of the Northwest Region (Exhibit III.B.1(e)) that are enrolled with the Medicaid program but are not actively participating. Because there are members enrolled in the FFS program in these counties (see below), the northern counties may be underserved in the area of primary care. In particular, this includes Kittson, Roseau and Lake of the Woods Counties.

Exhibit III.B.1(c)
Density Map of Unduplicated FFS Members in the Northwest Region
1 Dot = 50 FFS Members

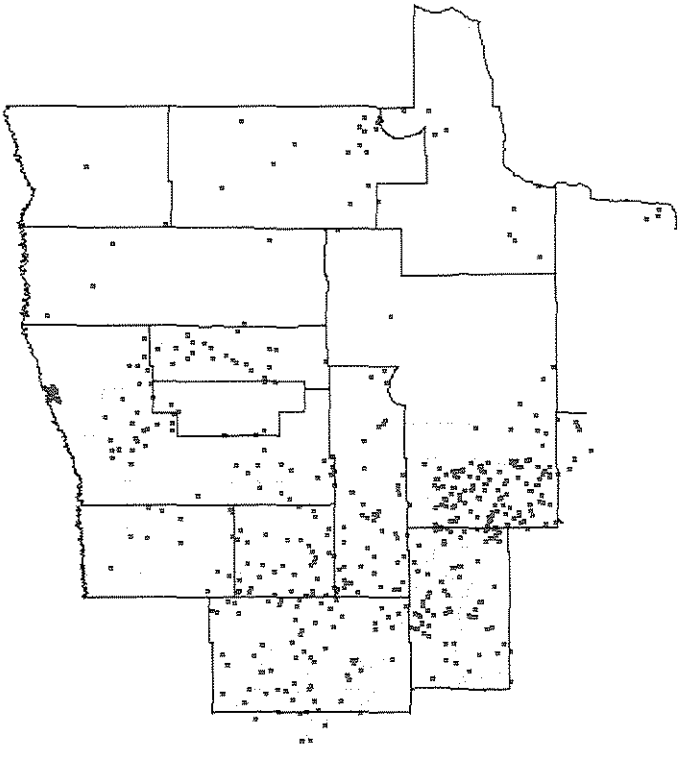


Exhibit III.B.1(d)
Density Map of Active FFS Primary Providers in the Northwest Region

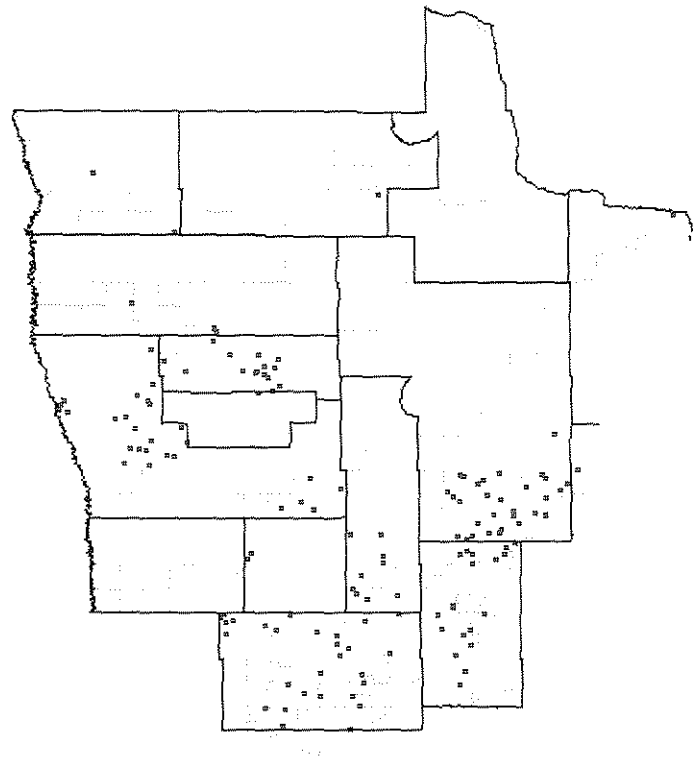
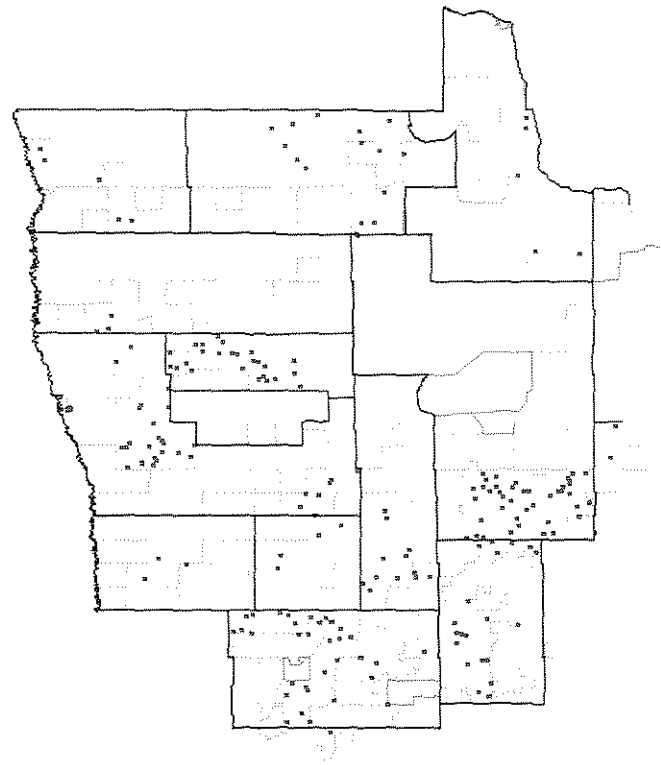


Exhibit III.B.1(e)
Density Map of All FFS Primary Providers in the Northwest Region



Exhibits III.B.1(f) and III.B.1(g) on the following pages reproduce the results discussed in Section III.A but for the Northwest Region only. Roseau, Lake of the Woods, Norman and Mahnomen Counties have low availability when only Active FFS providers are considered, meaning that there are more than 500 FFS members in the county for every active FFS primary care provider. But when All FFS providers are considered, three of these counties move to medium availability (101 to 500 members per provider) while Roseau County moves to high availability (less than 100 members per provider). Availability also improves for Polk County, which moves from medium to high.

On page 20, adding Medicaid managed care primary providers to the equation only shows significant improvement for Becker County (medium to high availability). FFS members in Red Lake County do not have availability to primary care providers in private office locations but do have access through Indian Health facilities in the county.

Exhibit III.B.1(h), which appears on page 21, matches the level of FFS enrollment in each county against the participation rates of potential primary care providers to the FFS program. Eight of the 13 counties in the Northwest Region were in the highest quartile of counties statewide for FFS member enrollment. The statewide average for the ratio of Active FFS providers to total potential Medicaid providers is 44 percent. Yet six of the eight counties designated as "high FFS enrollment" counties in the region had ratios above the statewide average. In fact, the region-wide ratio of Active FFS providers to total potential providers is 57 percent. Notably different from the region-wide average were Kittson (30%), Lake of the Woods (17%), Marshall (40%), Norman (25%) and Roseau (10%). However, only Lake of the Woods is a high FFS enrollment county.

Exhibit III.B.1(i), also on page 21, matches the level of availability to Active FFS providers which was shown in Exhibit III.B.1(f) against actual member usage of primary care providers. The exhibit is intended to measure if low *availability* of FFS providers results in low *usage* of primary care services or of higher ER usage. Office visits and ER visits are shown throughout Section III.B on a per 1,000 FFS member basis so that results can be compared across counties and regions with different levels of Medicaid participation. The per 1,000 ratios reflect utilization in the two-year period of SFYs 2007-2008.

The exhibit shows that the Northwest Region has higher utilization per 1,000 members for both office visits and ER visits than the statewide averages. Low availability of primary care providers in Lake of the Woods, Norman and Roseau Counties may result in a lower number of office visits. Each reported office visits per 1,000 members significantly below the region average (2,416 per 1,000) and the statewide average (1,600 per 1,000). The ER usage in these counties, however, is also substantially lower than the region average (488 per 1,000) and the statewide average (255 per 1,000). These data suggest that although physician availability may be low, members are not necessarily seeking care in the ER as an alternative. Mahnomen County is another exception to the low availability/low usage correlation in the Northwest Region. Members in this county have more than double the office visit utilization of the statewide average but lower ER usage than their region's average.

Exhibit III.B.1(f)
Comparison of FFS Members per Active Primary Provider and All Primary Providers in the Northwest Region

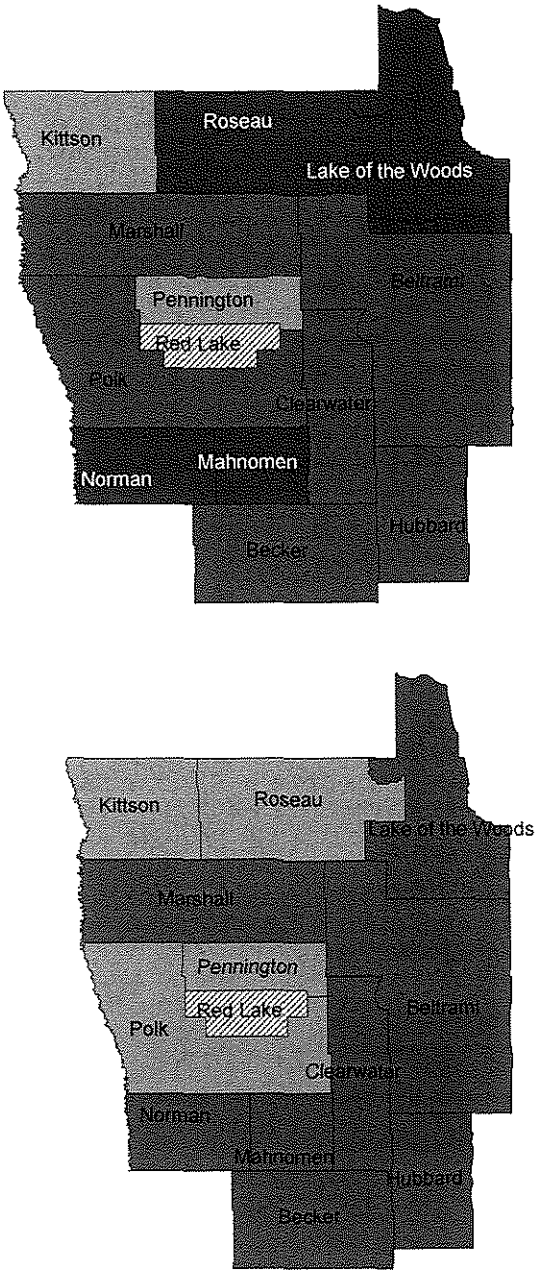


Exhibit III.B.1(g)
Comparison of FFS Members per All Medicaid FFS and Managed Care Primary Providers in the Northwest Region

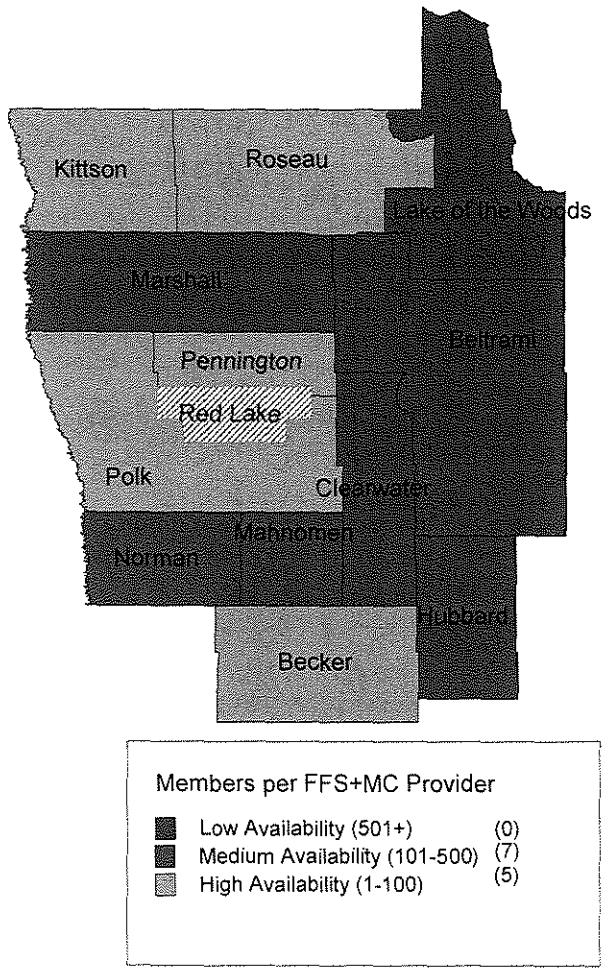


Exhibit III.B.1(h)
Summary of Potential Primary Care Provider Availability for Medicaid FFS Members in the Northwest Region

	Quartile FFS Enrollment	FFS Providers			Managed Care Providers	Total Primary Care Providers	Percent Active FFS Primary Care Providers
		Active	Limited	Inactive			
Region		**168**	**23**	**60**	**44**	**295**	**57%**
Becker	Highest	32	6	3	9	50	64%
Beltrami	Highest	57	1	16	14	88	65%
Clearwater	Highest	8	1	3	1	13	62%
Hubbard	Highest	17	1	3	3	24	71%
Kittson	Lowest	3	0	3	4	10	30%
Lake of the Woods	Highest	1	2	3	0	6	17%
Mahnomen	Highest	2	1	1	0	4	50%
Marshall	Lowest	2	1	2	0	5	40%
Norman	Mid-High	1	0	3	0	4	25%
Pennington	Mid-Low	18	2	6	2	28	64%
Polk	Highest	25	3	7	7	42	60%
Red Lake	Highest	0	0	0	0	0	0%
Roseau	Lowest	2	5	10	4	21	10%

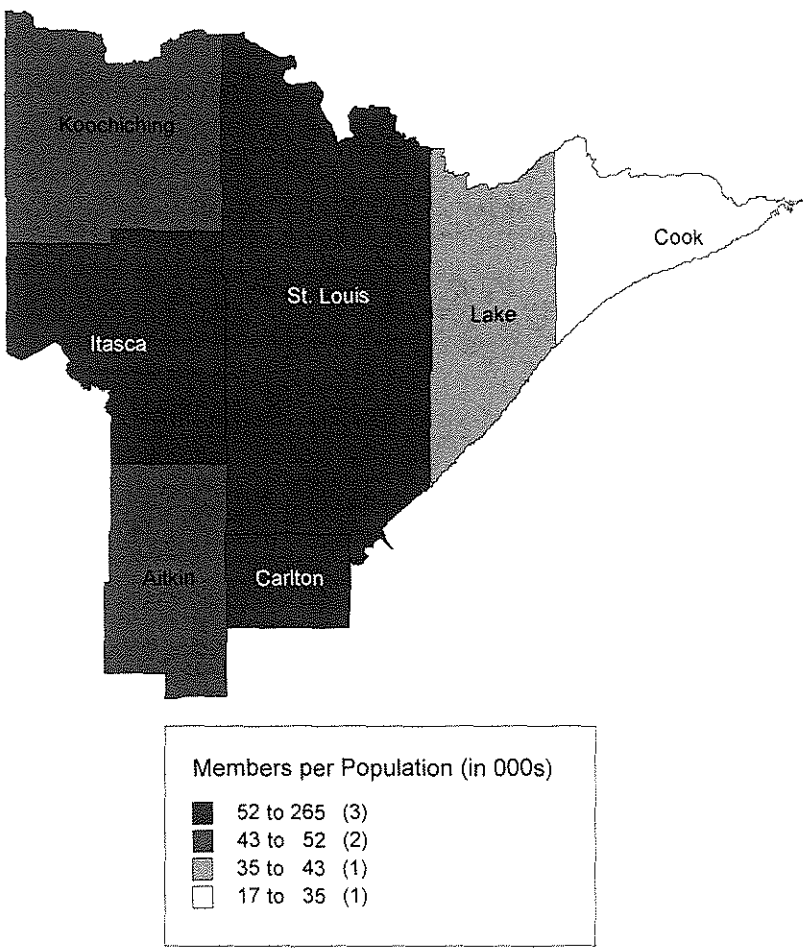
Exhibit III.B.1(i)
Primary Care Utilization for Medicaid FFS Members in the Northwest Region

		Pct of Services Utilized by Members from Primary Care Providers					
	Level of Access to Active FFS Providers	Office Visits	ER Visits	Other Hospital Visits	Other	Office Visits per 1,000 FFS Enrollees	ER Visits per 1,000 FFS Enrollees
Statewide		**50%**	**8%**	**13%**	**29%**	**1,600**	**255**
Region		**55%**	**11%**	**7%**	**27%**	**2,416**	**488**
Becker	Medium	60%	9%	7%	25%	2,831	420
Beltrami	Medium	56%	14%	6%	23%	2,944	759
Clearwater	Medium	47%	13%	8%	31%	1,316	374
Hubbard	Medium	41%	8%	6%	44%	2,088	430
Kittson	High	51%	3%	16%	29%	1,011	64
Lake of the Woods	Low	57%	6%	11%	26%	366	39
Mahnomen	Low	68%	7%	8%	17%	3,565	389
Marshall	Medium	49%	8%	7%	36%	1,343	221
Norman	Low	49%	5%	16%	30%	831	81
Pennington	High	55%	9%	7%	29%	2,117	346
Polk	Medium	57%	4%	10%	29%	1,925	141
Red Lake	No Providers	60%	5%	5%	31%	1,886	152
Roseau	Low	44%	5%	17%	34%	331	34

Northeast Region

The Northeast Region is comprised of seven counties and represents 6.2% of the total state population. Medicaid FFS enrollment is slightly higher than the overall population at 7.6%. This is evidenced in Exhibit III.B.2(a) which shows that five of the seven counties have FFS enrollment in the two upper quartiles when compared to all counties.

Exhibit III.B.2(a)
July 2007 FFS Members per July 2007 Census Estimate



The FFS primary care provider base in the Northeast Region reflects the FFS enrollment (7.1% of all statewide FFS providers). Among the 634 providers, this region also has a higher percentage of active providers than the statewide average.

Exhibit III.B.2(b)
Medicaid FFS Primary Care Provider Base in the Northeast Region

	Active	Limited	Inactive	Total
Northeast Providers	416	77	141	634
Percent of Total	66%	12%	22%	100%
Distribution Statewide	55%	16%	29%	100%

The exhibit below shows the location of FFS members in the Northeast Region. Comparing this to the exhibits on the next page which plot the available Primary Care providers in the region, it appears that, in general, the members have providers available to them near where they live. In Itasca County, there are considerably more potential FFS providers (refer to Exhibit III.B.2(e)) than are currently active (refer to Exhibit III.B.2(d)).

Exhibit III.B.2(c)
Density Map of Unduplicated FFS Members in the Northeast Region
1 Dot = 50 FFS Members

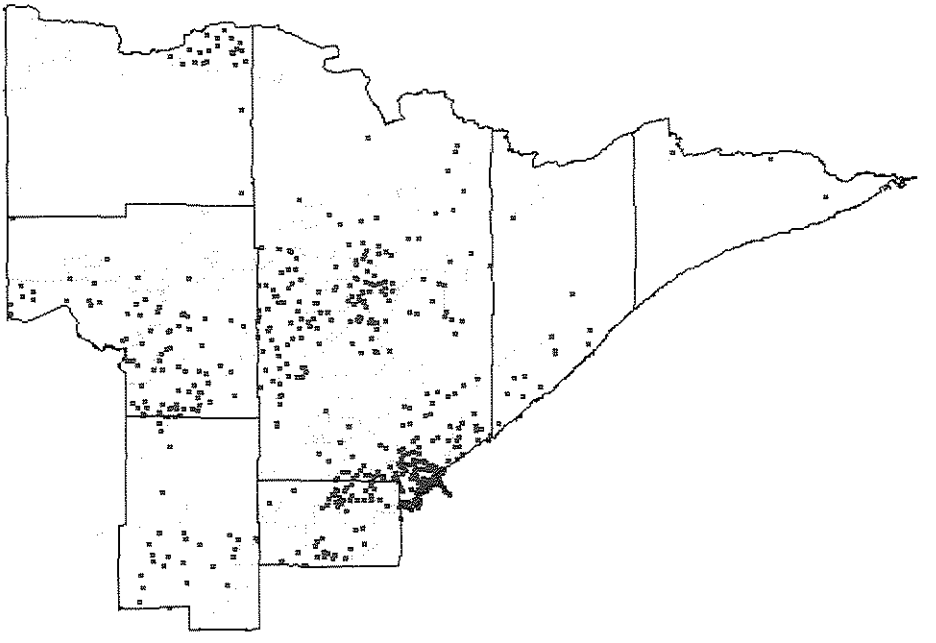


Exhibit III.B.2(d)
Density Map of Active FFS Primary Providers in the Northeast Region

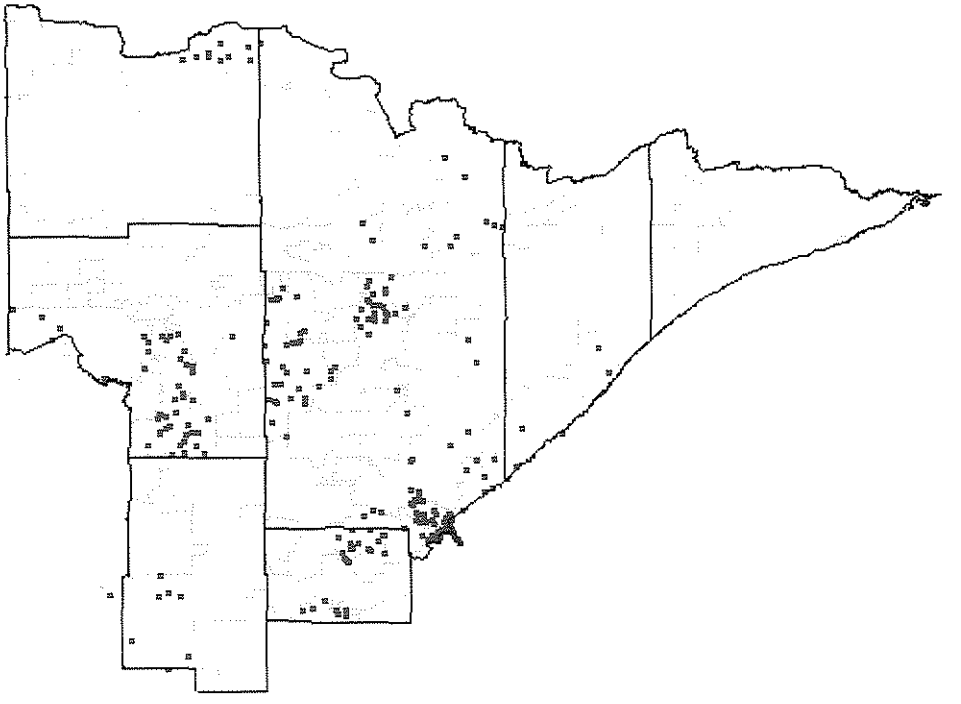
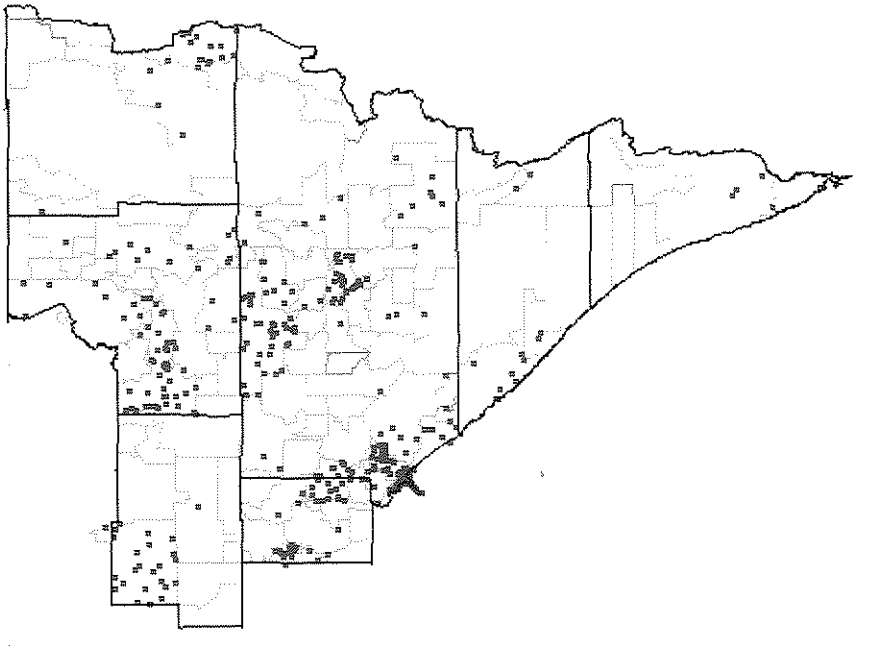


Exhibit III.B.2(e)
Density Map of All FFS Primary Providers in the Northeast Region



Exhibits III.B.2(f) and III.B.2(g) on the following pages examine the results from the Northeast Region with respect to actual versus potential primary care providers. Cook County does not have any Active FFS Primary Care providers, but when all FFS providers are considered, Cook County moves to a high availability county status. Likewise, the other six counties in the region are high availability counties when All FFS Primary Care providers are included in the ratio of members to providers. Exhibit III.B.1(g) includes the additional 137 Medicaid managed care primary providers. Although the map shows the same results as the prior page, the ratio of members to providers in each county improves with the addition of managed care providers. County results improve from 50 to 84 members per provider when FFS-only providers are included to 41 to72 members per provider when FFS plus managed care are included.

Exhibits III.B.2(h) and III.B.2(i), which appear on page 28, measure the relationship between availability and utilization of primary care services in the Northeast Region's counties. The three counties designated as "high FFS enrollment" counties (Carlton, Itasca and St. Louis) are also the counties with the highest ratio of Active FFS primary care providers to total FFS primary care providers. The Northeast Region's overall ratio of 54 percent also exceeds the statewide ratio of 44 percent.

Although provider availability (based on number of providers) does not appear to be an issue except for Cook County, Exhibit III.B.2(i) examines service availability based on what was utilized by FFS members. Counties within the Northeast Region vary significantly in office visits and ER visits per 1,000 FFS members when compared to the statewide averages. Itasca County has the highest office visit and ER utilization in the region (on a per 1,000 basis) which is also higher than the statewide average. St. Louis County also has higher office visit utilization. Alternatively, Aitkin, Cook and Lake Counties have very low office visit utilization. Aitkin and Lake Counties have ER utilization near the Northeast Region average but higher than the statewide average. Interestingly, Cook County—which has no Active FFS primary care providers—logically has the lowest office visit utilization but it also has the lowest ER utilization of any of the counties in the region. Cook County ranks third, however, among counties statewide for the proportion of primary care provider claims for hospital-based evaluations or consultations. This could mean that FFS members are hospitalized more frequently here than in most counties in the state.

Exhibit III.B.2(f)
Comparison of FFS Members per Active Primary Provider and All Primary Providers in the Northeast Region

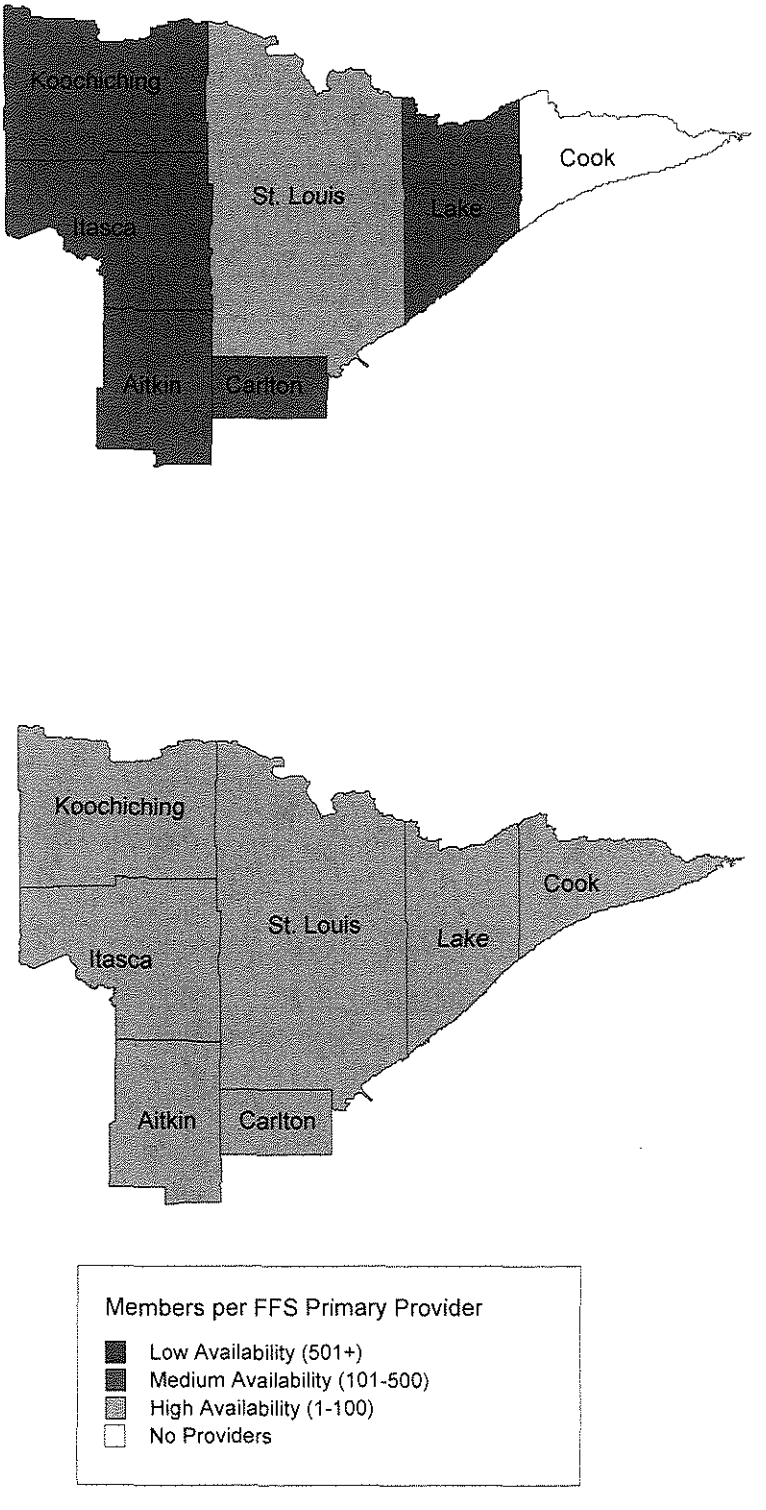


Exhibit III.B.2(g)
Comparison of FFS Members per All Medicaid FFS and Managed Care Primary Providers in the Northeast Region

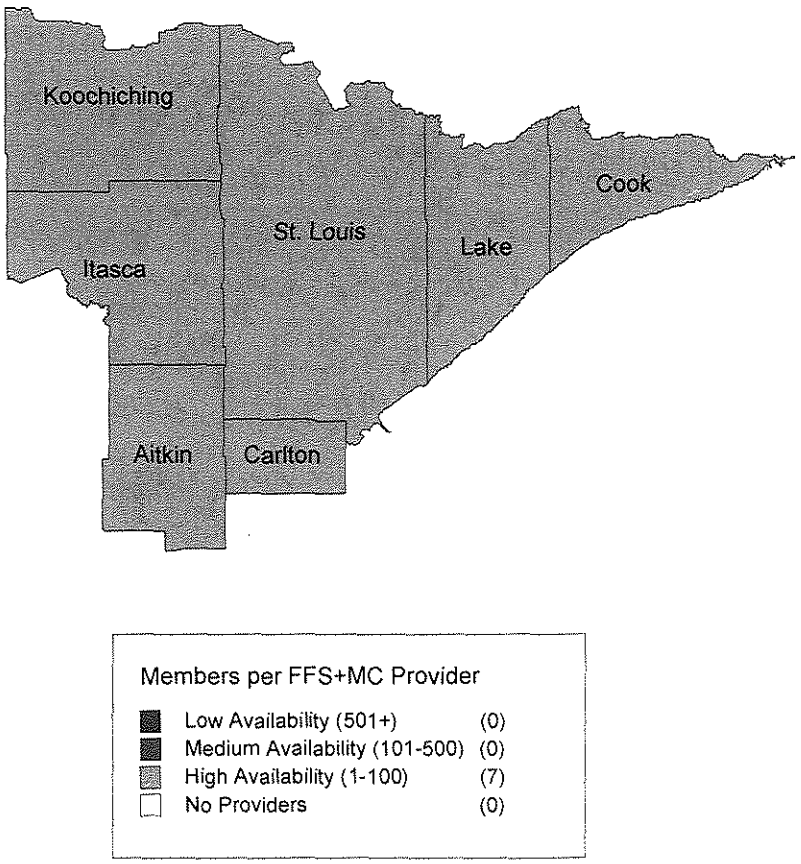


Exhibit III.B.2(h)
Summary of Potential Primary Care Provider Availability for Medicaid FFS Members in the Northeast Region

	Quartile FFS Enrollment	FFS Providers			Managed Care Providers	Total Primary Care Providers	Percent Active FFS Primary Care Providers
		Active	Limited	Inactive			
Region		**416**	**77**	**141**	**137**	**771**	**54%**
Aitkin	Mid-High	9	5	13	1	28	32%
Carlton	Highest	29	9	8	9	55	53%
Cook	Lowest	0	2	2	2	6	0%
Itasca	Highest	47	4	12	11	74	64%
Koochiching	Mid-High	10	2	8	5	25	40%
Lake	Mid-Low	6	4	3	7	20	30%
St. Louis	Highest	315	51	95	102	563	56%

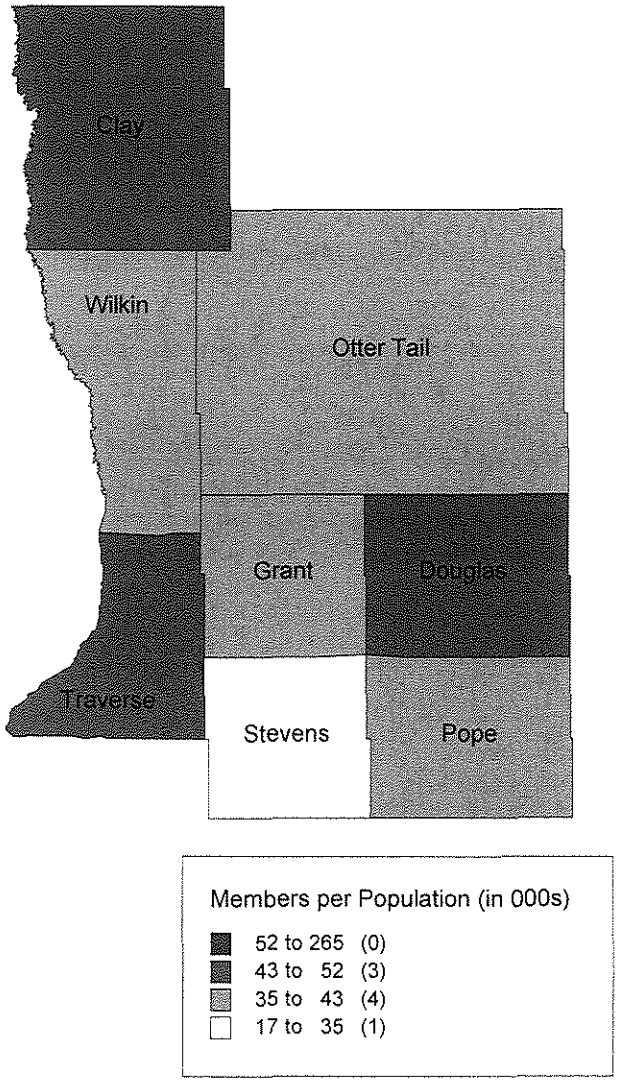
Exhibit III.B.2(i)
Primary Care Utilization for Medicaid FFS Members in the Northeast Region

		Pct of Services Utilized by Members from Primary Care Providers					
	Level of Access to Active FFS Providers	Office Visits	ER Visits	Other Hospital Visits	Other	Office Visits per 1,000 FFS Enrollees	ER Visits per 1,000 FFS Enrollees
Statewide		**50%**	**8%**	**13%**	**29%**	**1,600**	**255**
Region		**51%**	**10%**	**10%**	**30%**	**1,962**	**365**
Aitkin	Medium	41%	21%	16%	22%	724	372
Carlton	Medium	56%	8%	9%	27%	1,673	249
Cook	No Providers	38%	4%	29%	29%	717	78
Itasca	Medium	56%	14%	8%	22%	2,127	537
Koochiching	Medium	53%	3%	7%	37%	1,715	85
Lake	Medium	38%	16%	18%	29%	956	390
St. Louis	High	50%	9%	10%	32%	2,118	361

West Central Region

The West Central Region is comprised of eight counties and represents 3.6% of the total state population. Medicaid FFS enrollment is similar to the overall population at 3.4%. Exhibit III.B.3(a) shows that most of the counties do not, on a proportional basis, have FFS enrollment that is very high or very low when compared to other counties in the state.

Exhibit III.B.3(a)
July 2007 FFS Members per July 2007 Census Estimate



The FFS primary care provider base in the West Central Region is proportionally lower than FFS enrollment (1.9% of all statewide FFS providers). Among the 171 providers, this region has a higher percentage of active providers than the statewide average.

Exhibit III.B.3(b)
Medicaid FFS Primary Care Provider Base in the West Central Region

	Active	Limited	Inactive	Total
West Central Providers	107	29	35	171
Percent of Total	63%	15%	23%	100%
Distribution Statewide	55%	16%	29%	100%

The exhibit below shows the location of FFS members in the West Central Region. Although there are few FFS members enrolled that live in Wilkin, Traverse and Grant Counties, there are no Active Primary Care providers available to these members (refer to Exhibit III.B.3(d) on the next page). There are providers available, however, to the members in these counties—they are just identified as Limited or Inactive in our study. Because our definitions of Active, Limited and Inactive are based on services billed by each provider, there may in fact not be an availability issue in these counties if it is found that the members in these counties did not need services during our study period. Comparing the members plotted on the exhibit below against all available providers on the next page reveals that the available providers in Wilkin, Traverse and Grant Counties are actually near where the FFS members live. For the other counties in the region, there is little difference between the location of Active providers versus All available FFS Primary Care providers.

Exhibit III.B.3(c)
Density Map of Unduplicated FFS Members in the West Central Region
1 Dot = 50 FFS Members

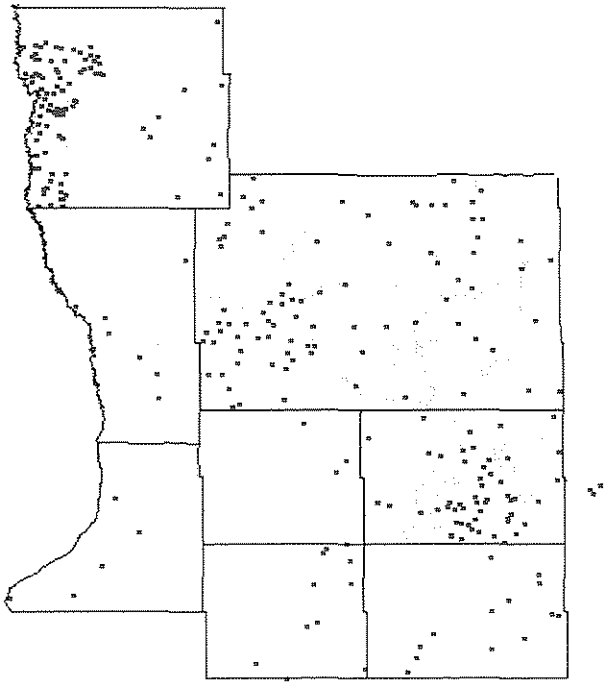


Exhibit III.B.3(d)
Density Map of Active FFS Primary Providers in the West Central Region

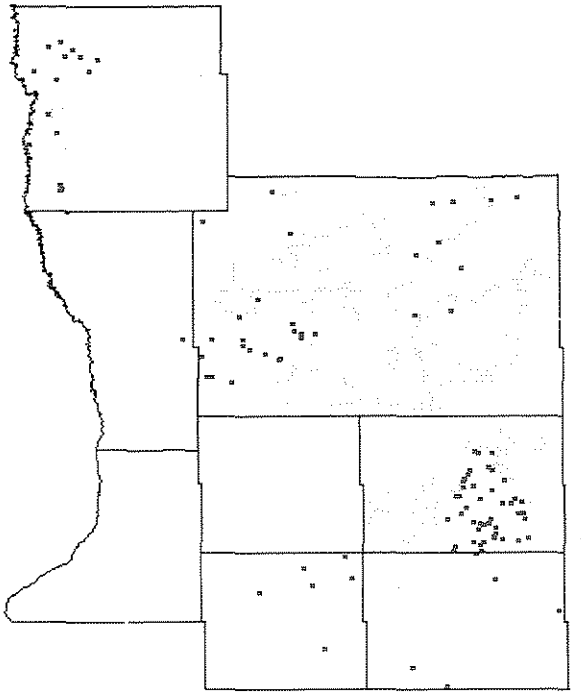
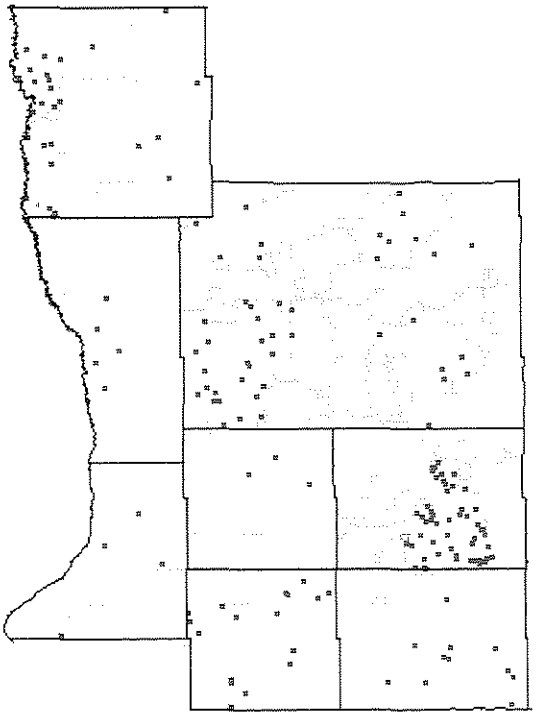


Exhibit III.B.3(e)
Density Map of All FFS Primary Providers in the West Central Region



Exhibits III.B.3(f) and III.B.3(g) on the following pages examine the results from the West Central Region with respect to actual versus potential primary care providers. Grant and Traverse Counties do not have any Active FFS Primary Care providers, but when all FFS providers are considered, both counties become classified as high availability counties. If managed care primary providers are also included (Exhibit III.B.3(g)), all but Clay County are deemed high availability.

Exhibits III.B.3(h) and III.B.3(i), which appear on page 35, measure the relationship between availability and utilization of primary care services in the West Central Region's counties. None of the counties in this region are in the upper quartile of "high FFS enrollment" counties in the state. Half of the available FFS primary care providers are classifies as active, which exceeds the statewide ratio of 44 percent. There are variances at the individual county level. In addition to the lack of any Active FFS primary care providers in Grant and Traverse Counties, there is a lower ratio of Active FFS providers in Clay, Pope and Wilkin Counties.

Exhibit III.B.3(i) shows evidence that potential availability of primary care does not appear to be directly correlated to actual utilization. For example, among the counties mentioned above with potential availability concerns, Clay and Wilkin Counties actually have higher office visits per 1,000 FFS members than the region average and the statewide average. They also have lower ER usage per 1,000 members. This implies no availability issues. It may also be true that the FFS members in these counties are accessing care from Minnesota Medicaid providers located in North Dakota. The other counties with potential availability concerns (Grant, Pope and Traverse) do have lower office visit usage per 1,000 members. But they also have lower ER usage per 1,000 members than the region average and the statewide average. Contrasted with this data is Douglas County, a high availability county but also a high ER visit county when compared to other counties in the region and the state. Likewise, Otter Tail County has Active FFS primary care availability similar to the statewide average but has higher ER utilization and lower office visit utilization than the region averages or the statewide averages.

Exhibit III.B.3(f)
Comparison of FFS Members per Active Primary Provider and All Primary Providers in the West Central Region

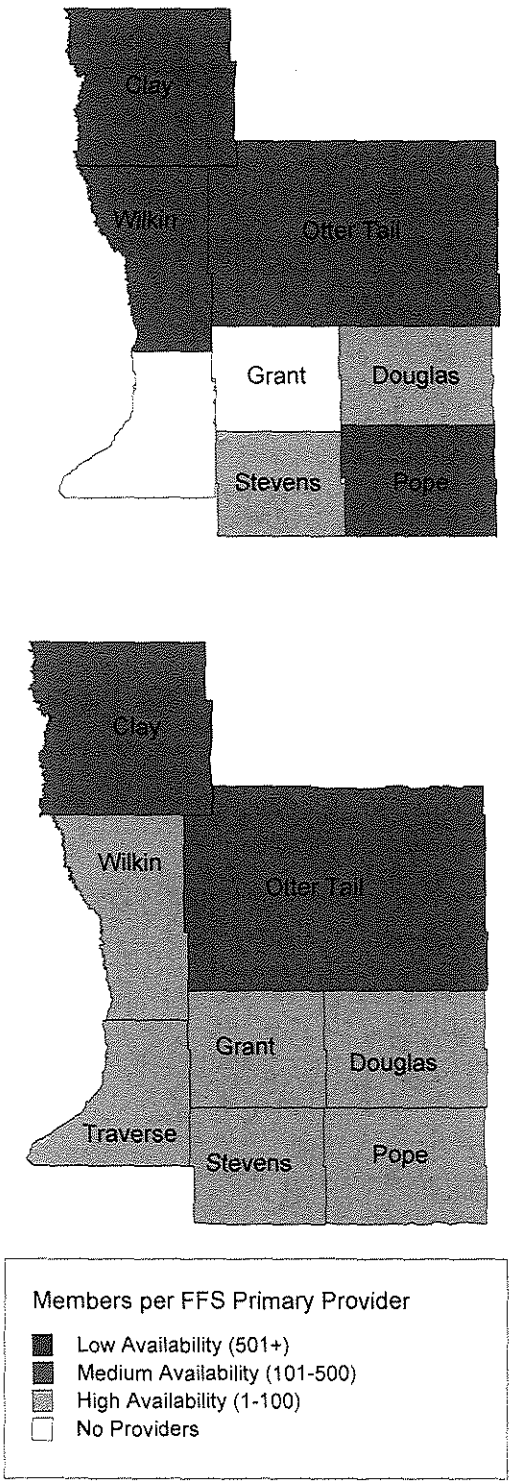


Exhibit III.B.3(g)
Comparison of FFS Members per All Medicaid FFS and Managed Care Primary Providers in the West Central Region

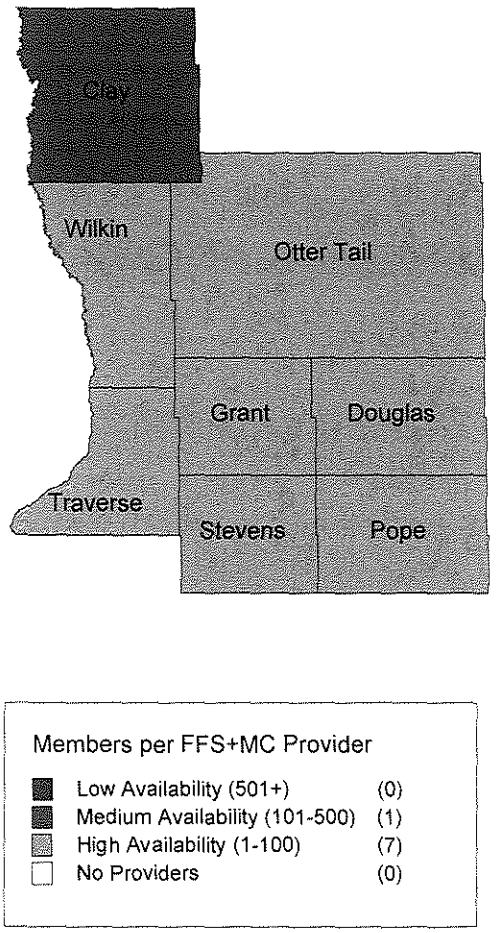


Exhibit III.B.3(h)
Summary of Potential Primary Care Provider Availability for Medicaid FFS Members in the West Central Region

	Quartile FFS Enrollment	FFS Providers			Managed Care Providers	Total Primary Care Providers	Percent Active FFS Primary Care Providers
		Active	Limited	Inactive			
Region		**107**	**25**	**39**	**38**	**209**	**51%**
Clay	Mid-High	14	3	9	6	32	44%
Douglas	Mid-High	46	3	5	16	70	66%
Grant	Mid-Low	0	4	1	1	6	0%
Otter Tail	Mid-Low	32	4	9	11	56	57%
Pope	Mid-Low	4	5	2	2	13	31%
Stevens	Lowest	10	4	7	0	21	48%
Traverse	Mid-High	0	2	2	1	5	0%
Wilkin	Mid-Low	1	0	4	1	6	17%

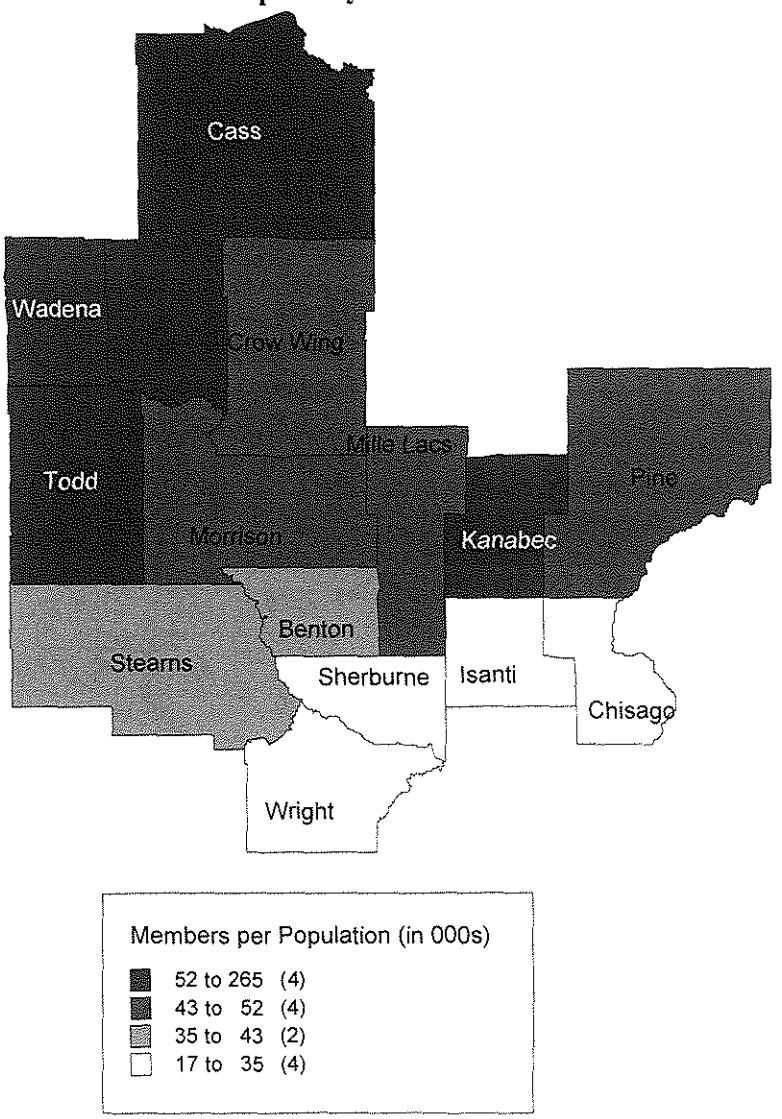
Exhibit III.B.3(i)
Primary Care Utilization for Medicaid FFS Members in the West Central Region

		Pct of Services Utilized by Members from Primary Care Providers					
	Level of Access to Active FFS Providers	Office Visits	ER Visits	Other Hospital Visits	Other	Office Visits per 1,000 FFS Enrollees	ER Visits per 1,000 FFS Enrollees
Statewide		**50%**	**8%**	**13%**	**29%**	**1,600**	**255**
Region		**52%**	**9%**	**10%**	**29%**	**1,639**	**299**
Clay	Medium	56%	5%	9%	30%	1,962	188
Douglas	High	54%	12%	5%	29%	1,879	402
Grant	No Providers	50%	12%	10%	28%	1,171	268
Otter Tail	Medium	43%	14%	12%	31%	1,189	387
Pope	Medium	55%	6%	15%	23%	1,272	147
Stevens	High	59%	9%	13%	20%	2,040	297
Traverse	No Providers	56%	12%	14%	18%	1,315	276
Wilkin	Medium	56%	5%	7%	32%	2,217	217

Central Region

The Central Region is comprised of 14 counties and represents 13.6% of the total state population. Medicaid FFS enrollment is similar to the overall population at 13.2%. Exhibit III.B.4(a) shows that the counties in the western part of the region have a disproportionately high number of FFS members and the southern counties have a disproportionately low number of FFS members when compared to other counties in the state.

Exhibit III.B.4(a)
July 2007 FFS Members per July 2007 Census Estimate



The FFS primary care provider base in the Central Region is proportionally lower than FFS enrollment (7.9% of all statewide FFS providers). However, this region has the highest percentage of active FFS providers of any of the eight regions examined.

Exhibit III.B.4(b)
Medicaid FFS Primary Care Provider Base in the Central Region

	Active	Limited	Inactive	Total
Central Providers	491	83	131	705
Percent of Total	70%	12%	19%	100%
Distribution Statewide	55%	16%	29%	100%

FFS members are spread throughout the Central Region with a higher concentration in Stearns, Sherburne and Wright Counties (see Exhibit III.B.4(c) below). Despite the fact that this region has the most Active FFS providers of any region in the state, there are many counties where there may still be a shortage of participating primary care providers. Specifically, the counties of Cass, Wadena, Todd and Pine all have limited availability of Active FFS Primary Care providers (refer to Exhibit III.B.4(d) on the next page). The first three of these counties also have disproportionately high FFS membership (refer back to Exhibit III.B.4(a)). If other available providers became more active in the FFS program in these counties, there may still be an availability issue because there are some locations where members live where there are no providers (compares the members in the exhibit below to the total available FFS providers in Exhibit III.B.4(e) on the next page).

Exhibit III.B.4(c)
Density Map of Unduplicated FFS Members in the Central Region
1 Dot = 50 FFS Members

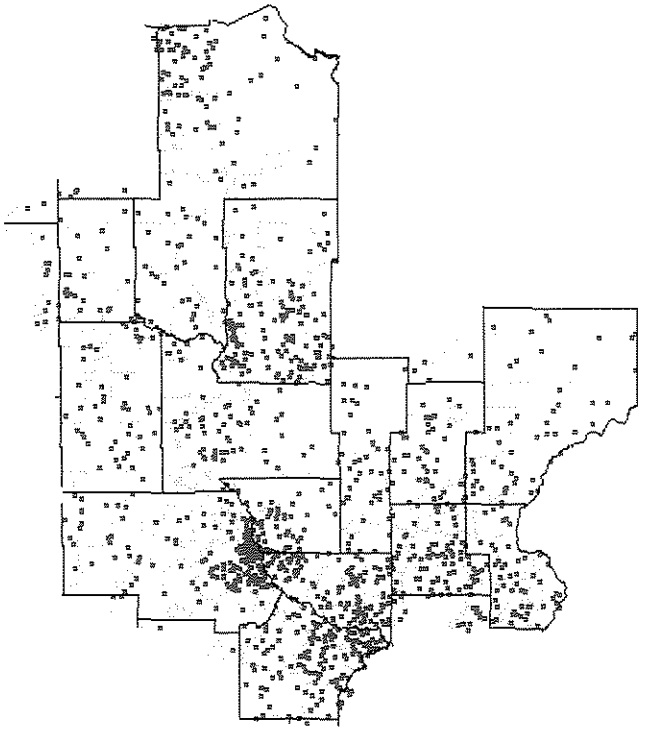


Exhibit III.B.4(d)
Density Map of Active FFS Primary Providers in the Central Region

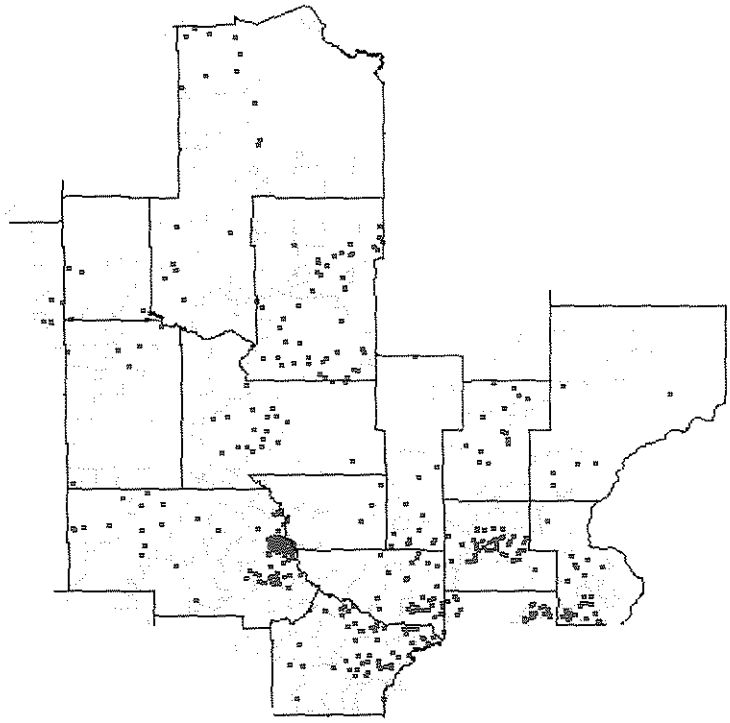
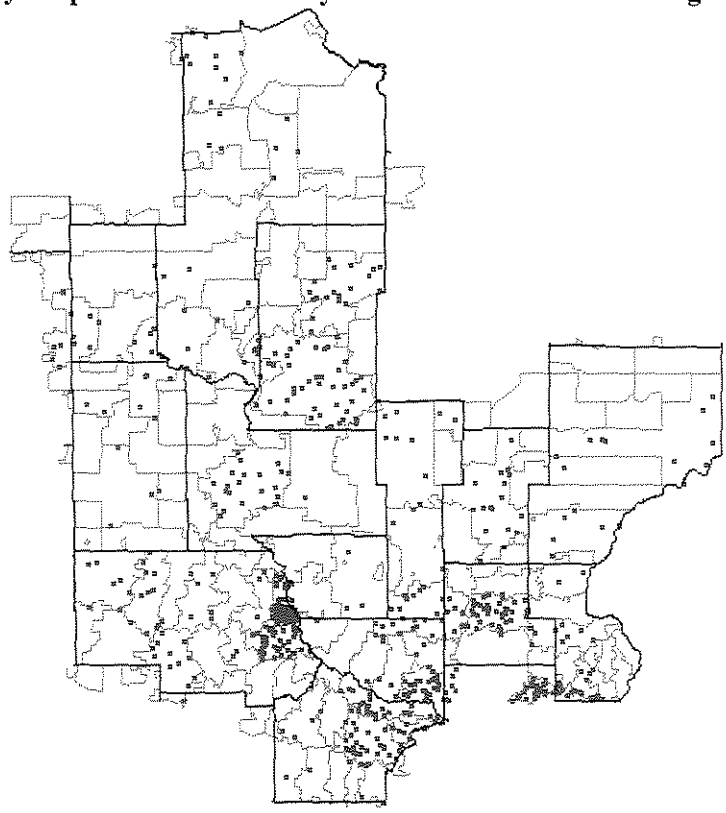


Exhibit III.B.4(e)
Density Map of All FFS Primary Providers in the Central Region



Exhibits III.B.4(f) and III.B.4(g) on the following pages reveal that, on a county level, availability of primary care providers for FFS members is similar whether the ratio of members to providers studied includes Active FFS providers only, all FFS providers, or FFS plus managed care providers. This reflects the previous finding that the Central Region has the highest proportion of Active FFS primary care providers of any region in the state. The one exception is Benton County which has limited availability under every scenario. However, given the county's relatively small geographic size and the fact that it borders four other counties, FFS members may be able to access providers in surrounding counties.

Exhibits III.B.4(h) and III.B.4(i) provide further evidence that Benton County may not suffer from availability problems. Exhibit III.B.4(i), appearing on page 42, shows that Benton County members' utilization of office visits (1,617 per 1,000) is higher than the Central Region average and higher than the statewide average while ER visits (95 per 1,000) is much lower than the region and statewide average. Cass County, meanwhile, is a county with one of the highest concentrations of FFS members in the state and has ER utilization (689 per 1,000) that is the second highest in the state. It also has one of the lowest percentages of Active FFS providers (40%) in the region. Crow King and Todd Counties have much lower office visit utilization than other counties in the region, but only Crow King has higher ER utilization. Todd County is in the upper quartile among counties with FFS member concentration.

Other counties in the Central Region show office visit and ER results similar to the region averages. The Central Region's ER utilization ratio of 255 per 1,000 is identical to the statewide ratio.

Exhibit III.B.4(f)
Comparison of FFS Members per Active Primary Provider and All Primary Providers in the Central Region

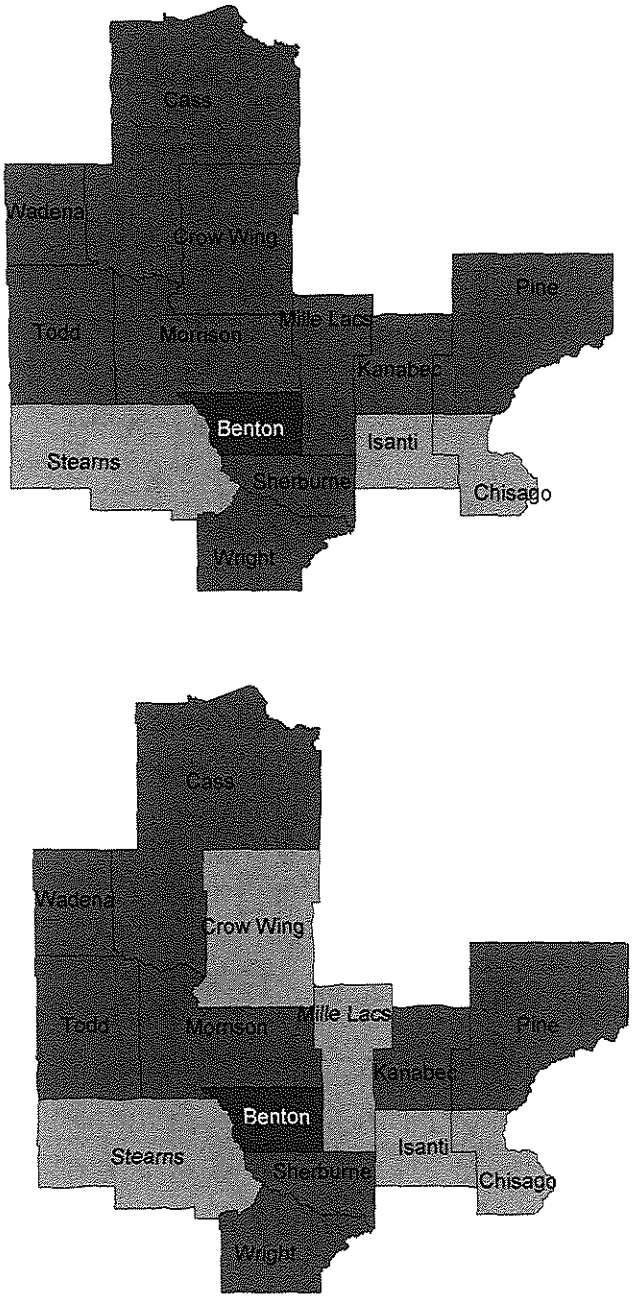


Exhibit III.B.4(g)
Comparison of FFS Members per All Medicaid FFS and Managed Care Primary Providers in the Central Region

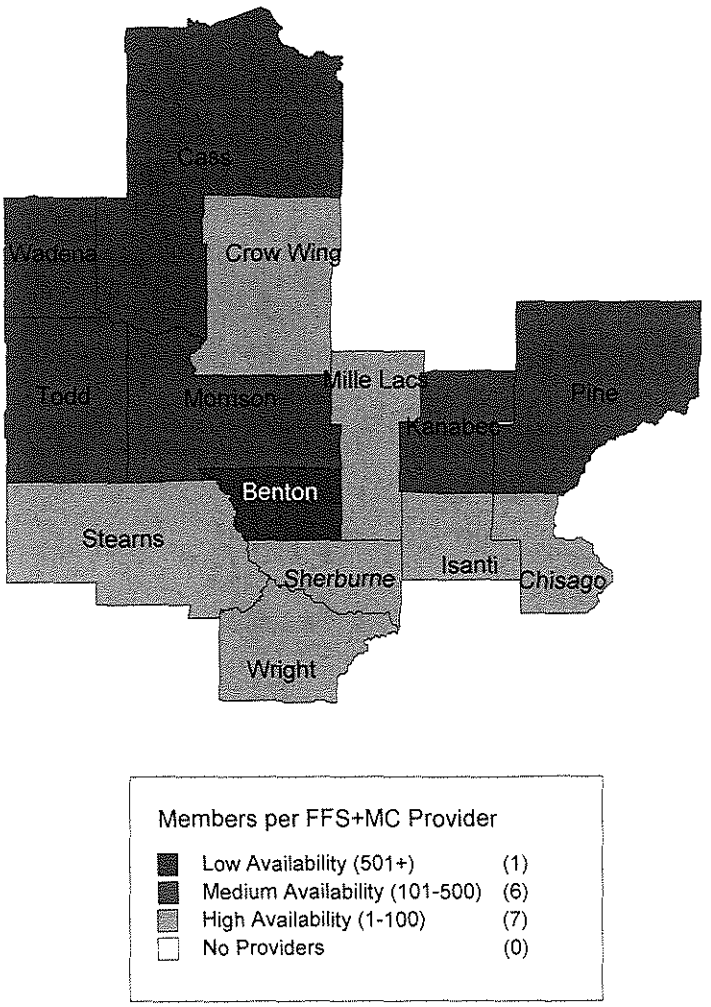


Exhibit III.B.4(h)
Summary of Potential Primary Care Provider Availability for Medicaid FFS Members in the Central Region

	Quartile FFS Enrollment	FFS Providers			Managed Care Providers	Total Primary Care Providers	Percent Active FFS Primary Care Providers
		Active	Limited	Inactive			
Region		**491**	**83**	**131**	**127**	**832**	**59%**
Benton	Mid-Low	4	0	0	1	5	80%
Cass	Highest	12	1	4	13	30	40%
Chisago	Lowest	46	6	3	8	63	73%
Crow Wing	Mid-High	47	12	16	10	85	55%
Isanti	Lowest	38	4	3	8	53	72%
Kanabec	Highest	12	1	4	2	19	63%
Mille Lacs	Mid-High	21	9	4	2	36	58%
Morrison	Mid-High	17	2	3	3	25	68%
Pine	Mid-High	6	4	6	6	22	27%
Sherburne	Lowest	35	5	10	7	57	61%
Stearns	Mid-Low	183	22	60	40	305	60%
Todd	Highest	12	6	4	4	26	46%
Wadena	Highest	9	1	2	4	16	56%
Wright	Lowest	49	10	12	19	90	54%

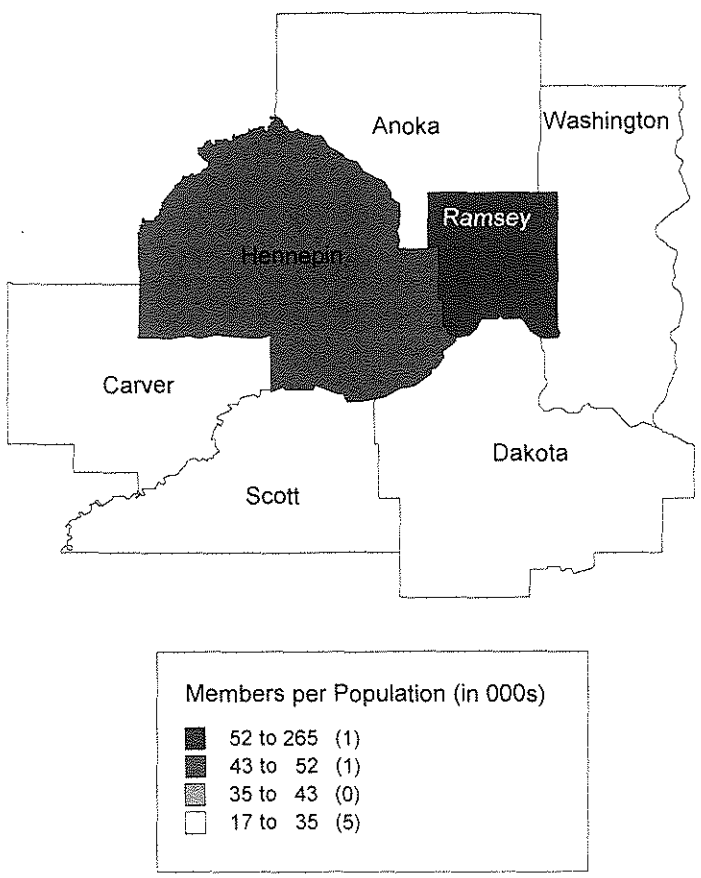
Exhibit III.B.4(i)
Primary Care Utilization for Medicaid FFS Members in the Central Region

		Pct of Services Utilized by Members from Primary Care Providers					
	Level of Access to Active FFS Providers	Office Visits	ER Visits	Other Hospital Visits	Other	Office Visits per 1,000 FFS Enrollees	ER Visits per 1,000 FFS Enrollees
Statewide		**50%**	**8%**	**13%**	**29%**	**1,600**	**255**
Region		**50%**	**10%**	**12%**	**29%**	**1,325**	**255**
Benton	Low	51%	3%	13%	33%	1,617	95
Cass	Medium	47%	20%	11%	22%	1,588	689
Chisago	High	53%	11%	13%	22%	1,842	383
Crow Wing	Medium	38%	18%	10%	34%	692	324
Isanti	High	54%	9%	11%	27%	1,709	278
Kanabec	Medium	51%	8%	13%	29%	1,405	217
Mille Lacs	Medium	49%	18%	14%	19%	1,200	433
Morrison	Medium	55%	3%	8%	34%	1,362	78
Pine	Medium	51%	8%	15%	26%	1,078	175
Sherburne	Medium	50%	10%	13%	27%	1,375	268
Stearns	High	50%	4%	12%	34%	1,444	107
Todd	Medium	40%	16%	16%	28%	552	226
Wadena	Medium	56%	7%	12%	25%	1,403	164
Wright	Medium	52%	8%	12%	28%	1,341	204

Metropolitan Region

The Metro Region is comprised of seven counties and represents 53.8% of the total state population. Medicaid FFS enrollment is slightly lower on a proportional basis at 49.9%. This is evidenced in Exhibit III.B.5(a) which shows that five of the seven counties are in the lowest quartile among all counties in the state when measuring FFS members per 1,000 residents.

Exhibit III.B.5(a)
July 2007 FFS Members per July 2007 Census Estimate



The FFS primary care provider base in the Metro Region is similar to FFS enrollment (53.9% of all statewide FFS providers). Active providers are slightly higher in this region than the statewide average.

Exhibit III.B.5(b)
Medicaid FFS Primary Care Provider Base in the Metro Region

	Active	Limited	Inactive	Total
Metro Providers	2,896	758	1,175	4,829
Percent of Total	60%	16%	24%	100%
Distribution Statewide	55%	16%	29%	100%

FFS members are spread throughout the Metro Region with the highest concentration around the Twin Cities (see Exhibit III.B.5(c) below). Primary Care providers in the FFS program—both Active and Total—are proportionally spread in the areas where the members are located (see Exhibits III.B.5(d) and (e) on the next page). Although Ramsey County has a higher proportion of FFS members per 1,000 population than other counties in the state (refer back to Exhibit III.B.5(a)), there appears to be sufficient availability of primary care services.

Exhibit III.B.5(c)
Density Map of Unduplicated FFS Members in the Metro Region
1 Dot = 50 FFS Members

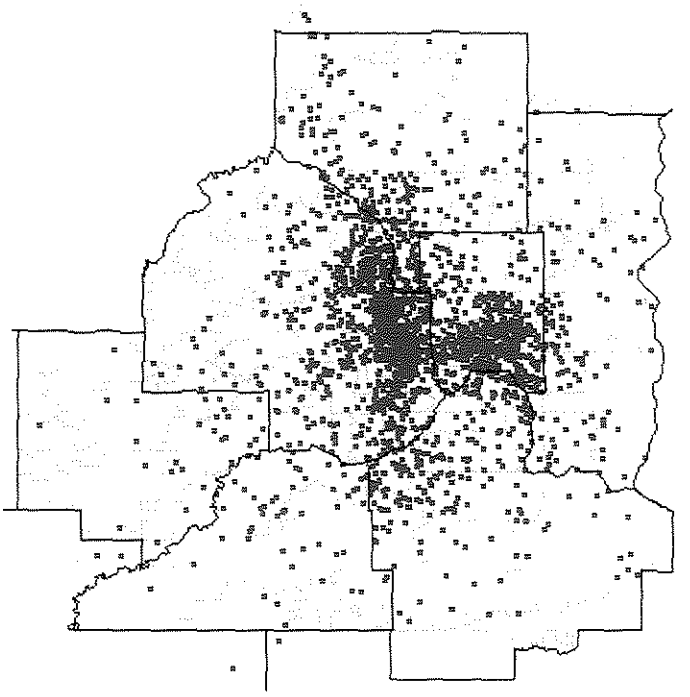


Exhibit III.B.5(d)
Density Map of Active FFS Primary Providers in the Metro Region

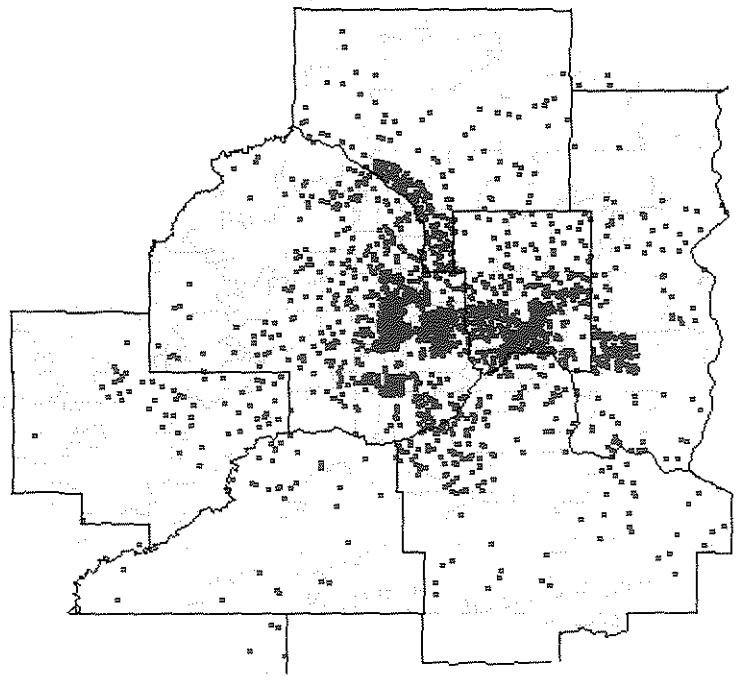
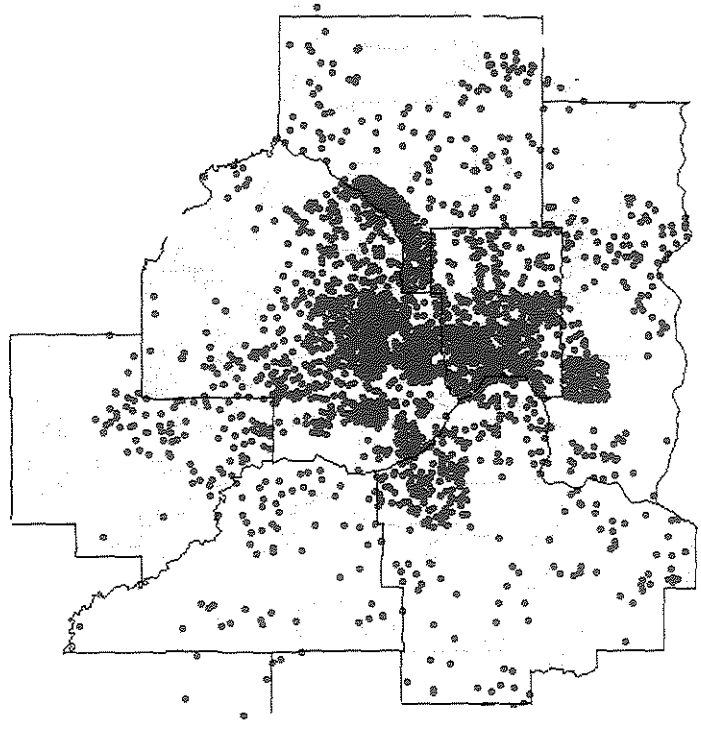


Exhibit III.B.5(e)
Density Map of All FFS Primary Providers in the Metro Region



Exhibits III.B.5(f) and III.B.5(g) on the following pages confirm that, at the county level, each of the counties in the Metro Region are ranked as medium or high availability counties in the state with respect to the availability of Active FFS Primary Care providers. This is further improved when all FFS providers, not just Active providers, are considered (refer to the bottom of III.B.5(f). Although the map shows the same results as the prior page, the ratio of members to providers in each county improves with the addition of managed care providers (refer to Exhibit III.B.5(g)). The median value for FFS members to providers among counties when FFS-only providers are included is 51; when managed care providers are also included it is 40.

Exhibits III.B.5(h) on page 49 further illustrates that availability of primary care for FFS enrollees is consistent in the counties of the Metro Region. The percent of Active FFS Primary Care providers in each county is in the range of 46 to 59 percent, with the region average at 48 percent. Office visits per 1,000 enrollees is also consistent across the counties (refer to Exhibit III.B.5(i)) with a range of 1,499 to 1,707 per 1,000 members. ER utilization varies more across the counties, from a low of 83 per 1,000 in Carver County to a high of 283 per 1,000 in Ramsey County. But event Ramsey and Washington Counties, though the highest in the Metro Region, still do not deviate much from the statewide ratio of 255 per 1,000.

Exhibit III.B.5(f)
Comparison of FFS Members per Active Primary Provider and All Primary Providers in the Metro Region

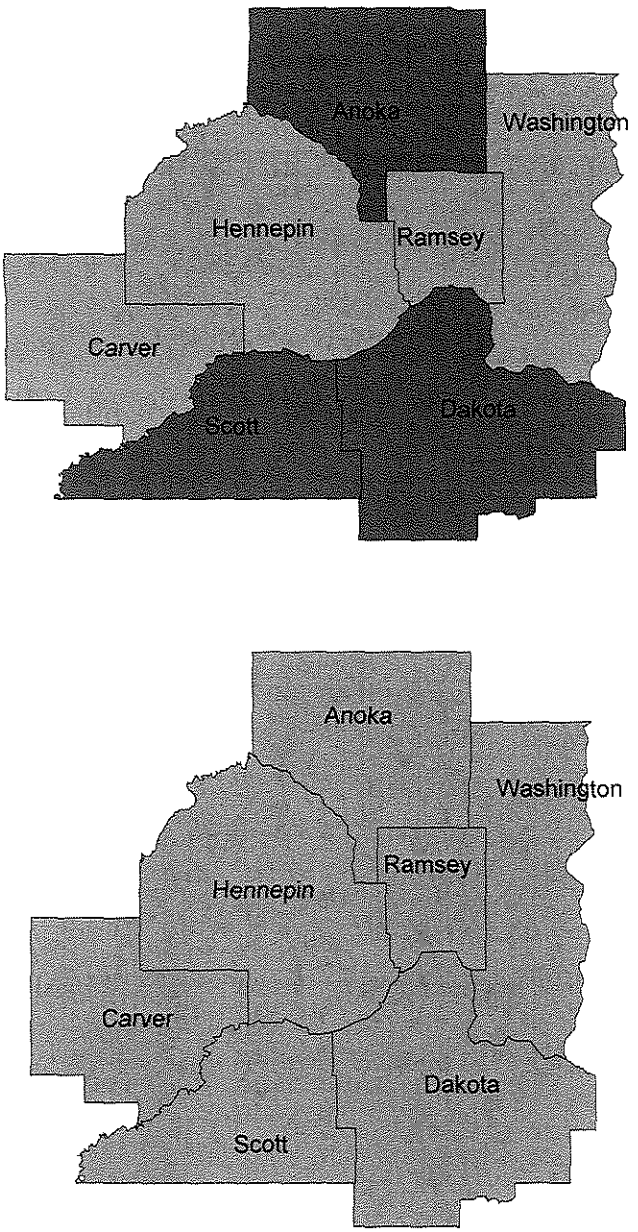


Exhibit III.B.5(g)
Comparison of FFS Members per All Medicaid FFS and Managed Care Primary Providers in the Metro Region

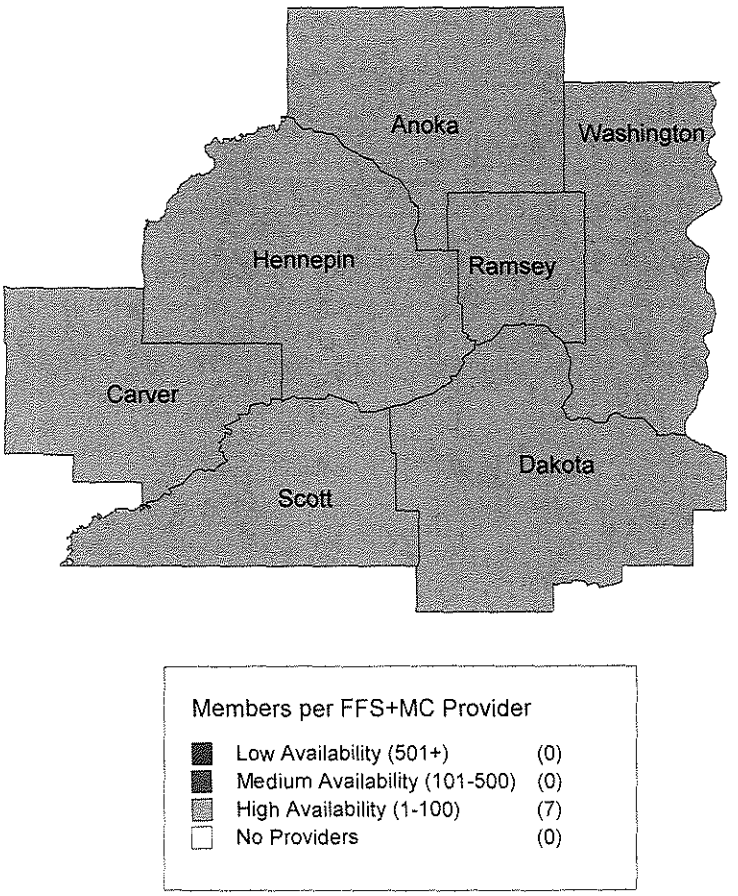


Exhibit III.B.5(h)
Summary of Potential Primary Care Provider Availability for Medicaid FFS Members in the Metro Region

	Quartile FFS Enrollment	FFS Providers			Managed Care Providers	Total Primary Care Providers	Percent Active FFS Primary Care Providers
		Active	Limited	Inactive			
Region		**2,896**	**758**	**1,175**	**1,191**	**6,020**	**48%**
Anoka	Lowest	213	41	125	81	460	46%
Carver	Lowest	52	21	11	15	99	53%
Dakota	Lowest	169	36	39	70	314	54%
Hennepin	Mid-High	1,578	420	694	674	3,366	47%
Ramsey	Highest	673	180	265	295	1,413	48%
Scott	Lowest	41	8	10	19	78	53%
Washington	Lowest	170	52	31	37	290	59%

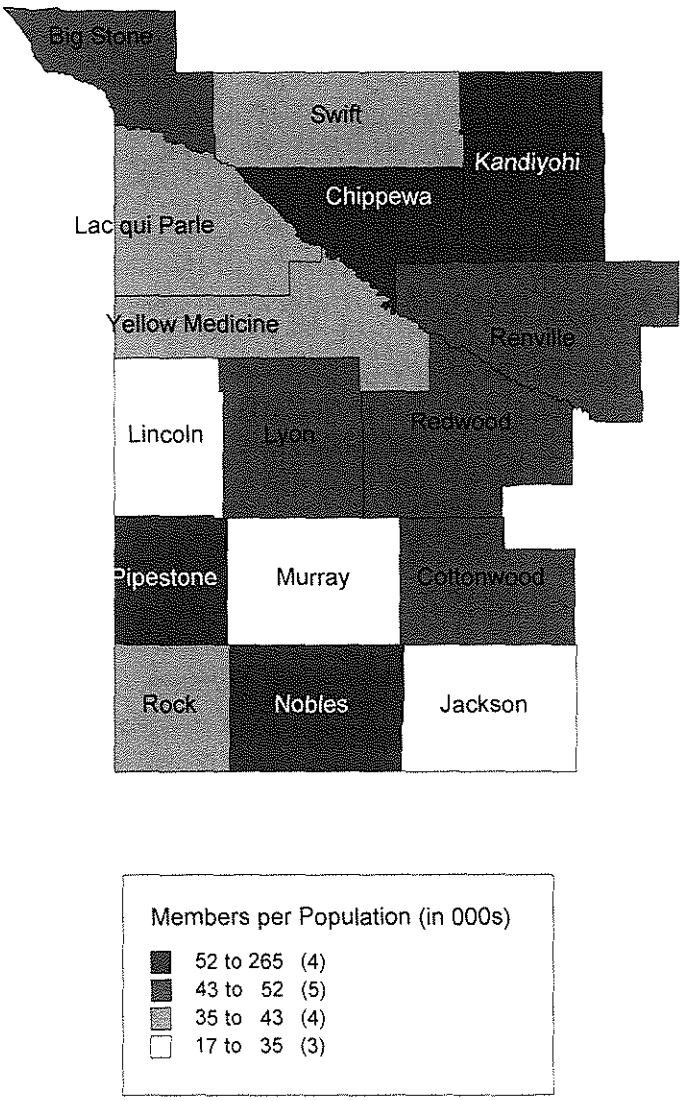
Exhibit III.B.5(i)
Primary Care Utilization for Medicaid FFS Members in the Metro Region

		Pct of Services Utilized by Members from Primary Care Providers					
	Level of Access to Active FFS Providers	Office Visits	ER Visits	Other Hospital Visits	Other	Office Visits per 1,000 FFS Enrollees	ER Visits per 1,000 FFS Enrollees
Statewide		**50%**	**8%**	**13%**	**29%**	**1,600**	**255**
Region		**49%**	**6%**	**15%**	**29%**	**1,577**	**204**
Anoka	Medium	52%	3%	15%	31%	1,707	96
Carver	High	57%	3%	9%	31%	1,499	83
Dakota	Medium	51%	6%	15%	28%	1,568	189
Hennepin	High	50%	6%	16%	28%	1,585	193
Ramsey	High	45%	8%	15%	32%	1,510	283
Scott	Medium	52%	4%	14%	31%	1,522	104
Washington	High	50%	8%	13%	29%	1,655	262

Southwest Region

The Southwest Region is comprised of 16 counties and represents 4.2% of the total state population. Medicaid FFS enrollment is similar at 4.5%. The counties in the region, however, have a wide range of FFS membership proportional to their population. This is shown in Exhibit III.B.6(a) which measures FFS members per 1,000 residents.

Exhibit III.B.6(a)
July 2007 FFS Members per July 2007 Census Estimate



The Southwest Region has 3.0% of the FFS primary care provider base in the state and the percentage of providers deemed Active in the FFS program resembles the statewide average.

Exhibit III.B.6(b)
Medicaid FFS Primary Care Provider Base in the Southwest Region

	Active	Limited	Inactive	Total
Southwest Providers	156	37	74	267
Percent of Total	58%	14%	28%	100%
Distribution Statewide	55%	16%	29%	100%

Other than concentrations of FFS members in Kandiyohi and Nobles Counties (proportionally high FFS counties in the state), FFS members are spread throughout the Southwest Region (see Exhibit III.B.6(c) below). There are Primary Care providers available in each of the counties in the region (refer to Exhibit III.B.6(e) on the next page); however, there are many counties in which the providers were not deemed Active based on claims submitted. This is especially true in Lac qui Parie, Yellow Medicine and Lincoln Counties in the western part of the region, Renville County in the eastern part, and Murray and Jackson Counties in the southern portion of the region (refer to Exhibit III.B.6(d) on the next page).

Exhibit III.B.6(c)
Density Map of Unduplicated FFS Members in the Southwest Region
1 Dot = 50 FFS Members

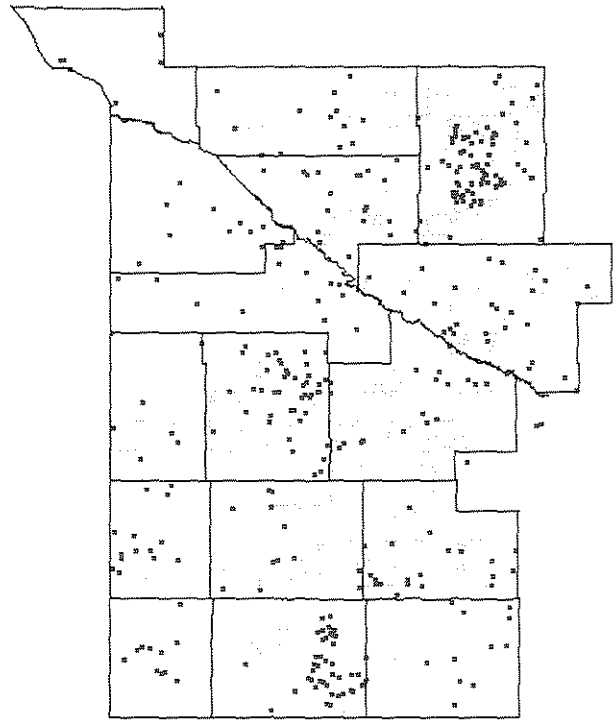


Exhibit III.B.6(d)
Density Map of Active FFS Primary Providers in the Southwest Region

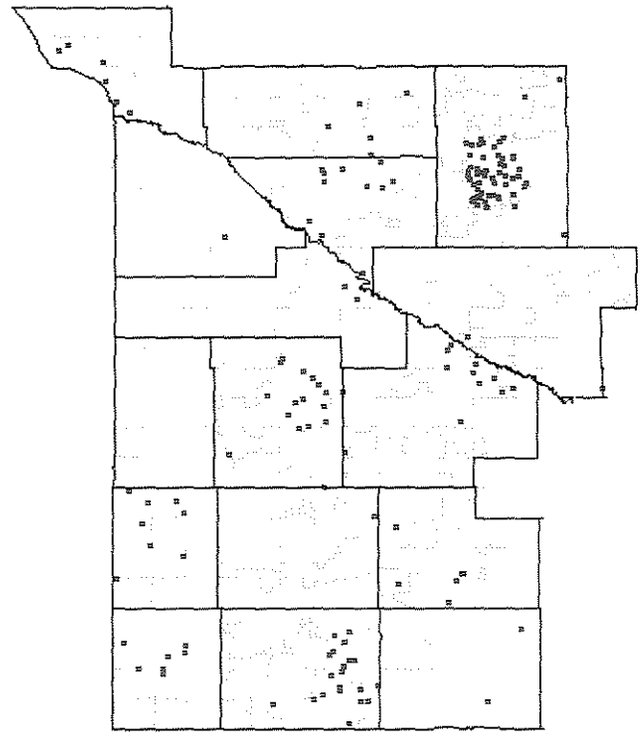
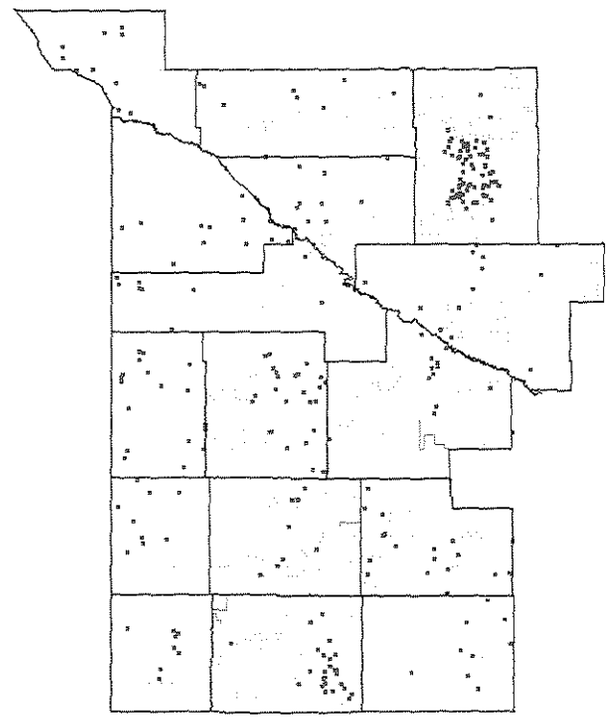


Exhibit III.B.6(e)
Density Map of All FFS Primary Providers in the Southwest Region



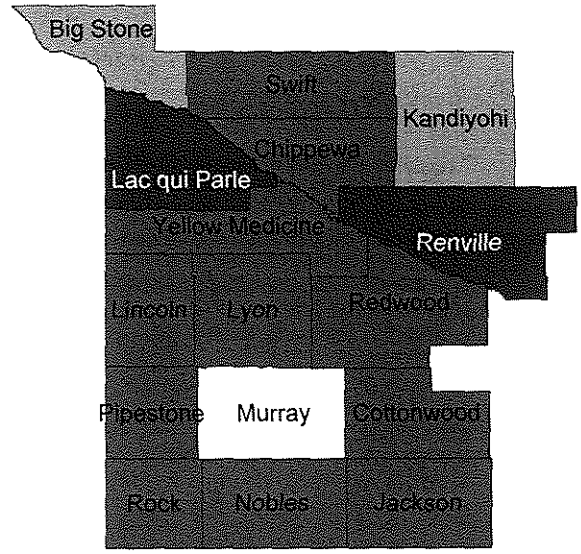
Exhibits III.B.6(f) and III.B.6(g) on the following pages show that availability of primary care for FFS members improves a great deal depending upon which providers are considered in the analysis. The top map in Exhibit III.B.6(f) shows that Murray County has no active providers while Luc qui Parle and Renville Counties has low availability. But when all FFS providers are considered (lower map in the exhibit), Luc qui Parle and Murray Counties become high availability counties and Renville becomes a medium availability county. If managed care primary care providers were included (Exhibit III.B.6(g)), only Chippewa and Renville Counties would remain medium availability counties.

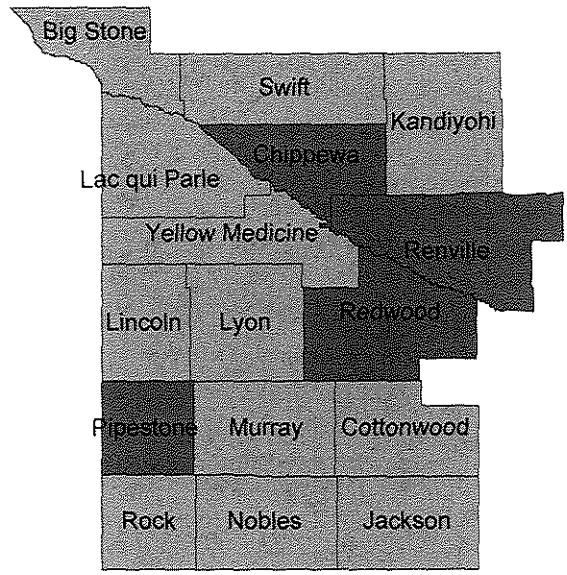
Exhibits III.B.6(h), which appears on page 56, shows that the counties in the highest quartile of "high FFS enrollment" counties in the state also have the highest proportion of Active FFS primary care providers. Each county is substantially higher (62% to 77% of total FFS providers) than either the region average of 47 percent or the statewide average of 44 percent. The Southwest Region, however, also has counties with some of the lowest Active FFS provider participation in the state, such as Lac qui Parle (9%), Lincoln (5%), Murray (0%) and Renville (8%). These counties could pose considerable concern to FFS members' availability of primary care.

Exhibit III.B.6(i) shows that this is true for office visit utilization. The Southwest Region as a whole has lower office visit utilization per 1,000 (1,394) than the statewide average (1,600). In the four counties with the lowest Active FFS provider participation, office visit utilization rate range from a low of 432 per 1,000 in Lac qui Parle County to 1,144 in Renville County. Despite this finding, each of these counties has very low ER utilization per 1,000. But, with the exception of Renville County, the other three counties have members who received a substantially higher number of in-hospital evaluations or consultations than other counties in the state. This implies that the inpatient and outpatient hospital setting (outside of the ER) may serve as a primary location where members are receiving services, a less cost effective place of service than the doctor's office. It should also be noted that these low utilization trends should be reviewed with the understanding that FFS members in the Southwest Region may also be accessing services from Minnesota Medicaid FFS providers in South Dakota and Iowa.

Most counties in the Southwest Region have FFS members utilizing office visits and ER visits below the statewide average. For office visits, the only exceptions are Kandiyohi (1,924 per 1,000), Nobles (1,885 per 1,000) and Pipestone (1,973 per 1,000), each of which is slightly above the statewide average (1,600 per 1,000).

Exhibit III.B.6(f)
Comparison of FFS Members per Active Primary Provider and All Primary Providers in the Southwest Region





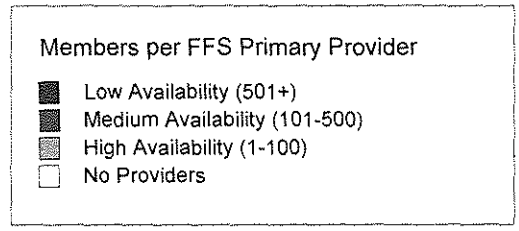


Exhibit III.B.6(g)
Comparison of FFS Members per All Medicaid FFS and Managed Care Primary Providers in the Southwest Region

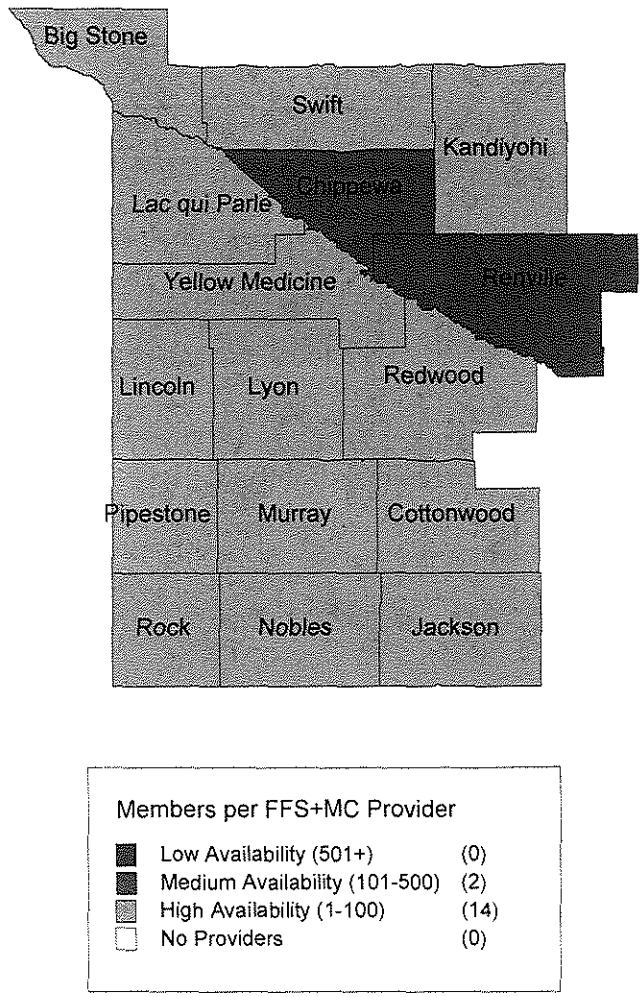


Exhibit III.B.6(h)
Summary of Potential Primary Care Provider Availability for Medicaid FFS Members in the Southwest Region

	Quartile FFS Enrollment	FFS Providers			Managed Care Providers	Total Primary Care Providers	Percent Active FFS Primary Care Providers
		Active	Limited	Inactive			
Region		**156**	**37**	**74**	**65**	**332**	**47%**
Big Stone	Mid-High	6	3	1	2	12	50%
Chippewa	Highest	10	0	0	3	13	77%
Cottonwood	Mid-High	6	3	9	9	27	22%
Jackson	Lowest	2	4	3	3	12	17%
Kandiyohi	Highest	57	8	6	8	79	72%
Lac Qui Parle	Mid-Low	1	1	9	0	11	9%
Lincoln	Lowest	1	2	13	6	22	5%
Lyon	Mid-High	17	4	8	11	40	43%
Murray	Lowest	0	0	6	4	10	0%
Nobles	Highest	20	0	5	6	31	65%
Pipestone	Highest	8	0	2	3	13	62%
Redwood	Mid-High	11	2	1	3	17	65%
Renville	Mid-High	1	5	4	3	13	8%
Rock	Mid-Low	7	1	0	2	10	70%
Swift	Mid-Low	6	0	4	0	10	60%
Yellow Medicine	Mid-Low	3	4	3	2	12	25%

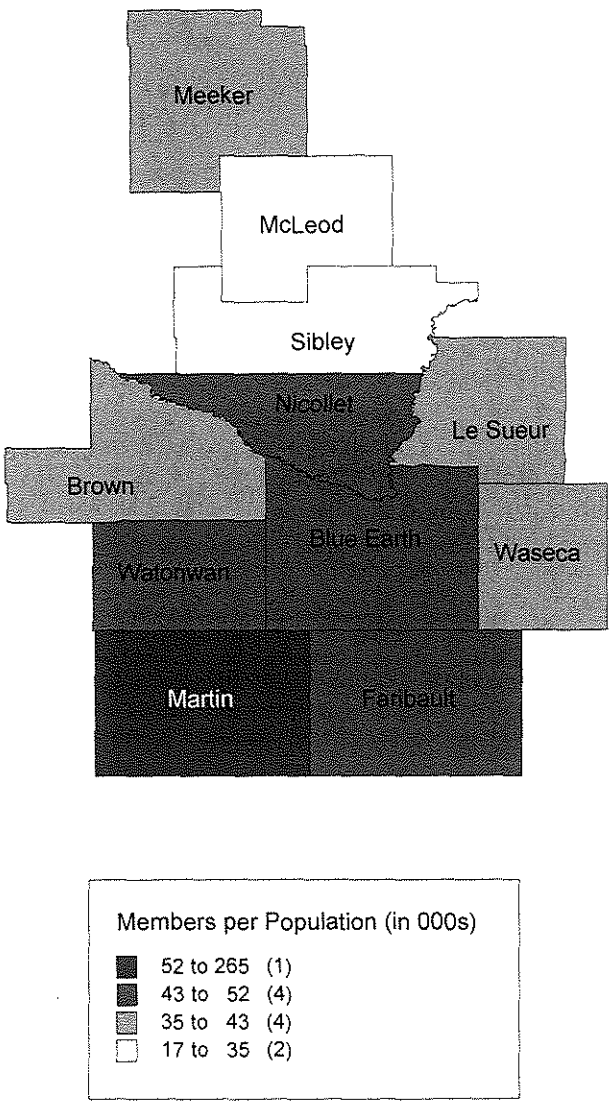
Exhibit III.B.6(i)
Primary Care Utilization for Medicaid FFS Members in the Southwest Region

		Pct of Services Utilized by Members from Primary Care Providers					
	Level of Access to Active FFS Providers	Office Visits	ER Visits	Other Hospital Visits	Other	Office Visits per 1,000 FFS Enrollees	ER Visits per 1,000 FFS Enrollees
Statewide		**50%**	**8%**	**13%**	**29%**	**1,600**	**255**
Region		**50%**	**6%**	**12%**	**32%**	**1,394**	**177**
Big Stone	High	54%	8%	9%	29%	1,383	215
Chippewa	Medium	48%	3%	15%	34%	1,027	71
Cottonwood	Medium	51%	7%	15%	27%	1,181	158
Jackson	Medium	46%	5%	17%	33%	919	97
Kandiyohi	High	51%	7%	7%	35%	1,924	253
Lac Qui Parle	Low	40%	4%	24%	32%	432	44
Lincoln	Medium	36%	5%	32%	26%	518	78
Lyon	Medium	46%	9%	13%	32%	1,050	200
Murray	No Providers	37%	3%	31%	30%	1,043	84
Nobles	Medium	53%	5%	8%	34%	1,885	171
Pipestone	Medium	58%	7%	12%	23%	1,973	239
Redwood	Medium	48%	11%	11%	30%	1,184	263
Renville	Low	51%	7%	12%	30%	1,144	167
Rock	Medium	51%	2%	14%	33%	1,318	41
Swift	Medium	51%	5%	12%	33%	1,493	140
Yellow Medicine	Medium	44%	5%	23%	28%	1,093	128

South Central Region

The South Central Region is comprised of 11 counties and represents 5.5% of the total state population. Medicaid FFS enrollment is similar at 5.5% of the statewide enrollment. At the county level, there is a wide range of FFS membership proportional to the total population. This is shown in Exhibit III.B.7(a).

Exhibit III.B.7(a)
July 2007 FFS Members per July 2007 Census Estimate



The FFS primary care provider base in the South Central Region is slightly lower than the percentage of FFS enrollment (4.0% of all statewide FFS providers). Active providers are slightly higher in this region than the statewide average.

Exhibit III.B.7(b)
Medicaid FFS Primary Care Provider Base in the South Central Region

	Active	Limited	Inactive	Total
South Central Providers	214	44	99	357
Percent of Total	60%	12%	28%	100%
Distribution Statewide	55%	16%	29%	100%

When comparing the FFS members against provider availability, the South Central Region may have some availability issues, particularly with respect to Primary Care providers we have identified as Active. There is a concentration of FFS members in the region in Sibley and Nicollet Counties down into Blue Earth County (see exhibit below). But there are very few Active Primary Care providers in Sibley and Nicollet Counties (refer to Exhibit III.B.7(d) on the next page). This is alleviated to some degree if enrolled but less active FFS providers are willing to serve the FFS members in these counties (refer to Exhibit III.B.7(e) on the next page). Active Primary Care providers are also limited in Brown and Watonwan Counties in the western part of the region, in Le Sueur and Waseca Counties in the eastern part, and Faribault County in the southern portion of the region.

Exhibit III.B.7(c)
Density Map of Unduplicated FFS Members in the South Central Region
1 Dot = 50 FFS Members

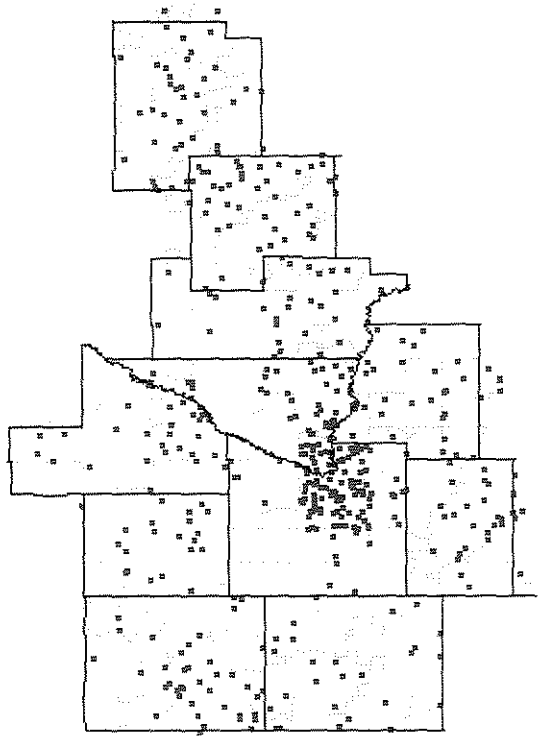


Exhibit III.B.7(d)
Density Map of Active FFS Primary Providers in the South Central Region

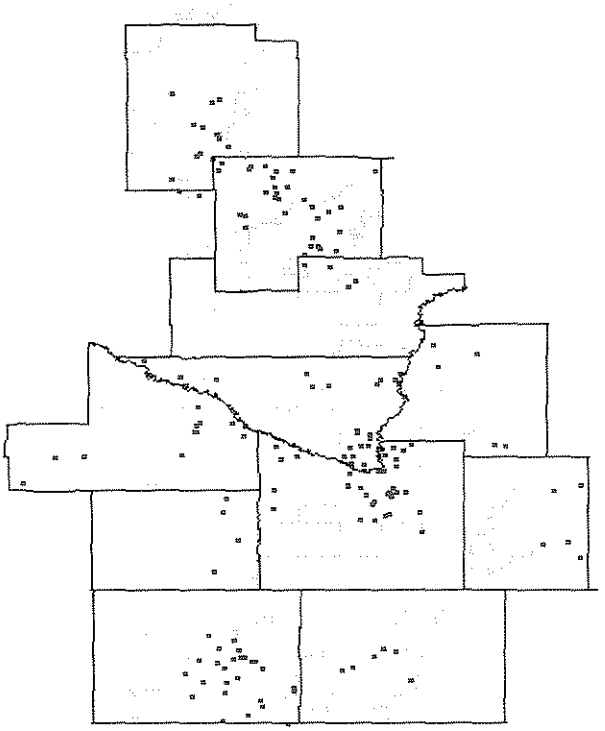
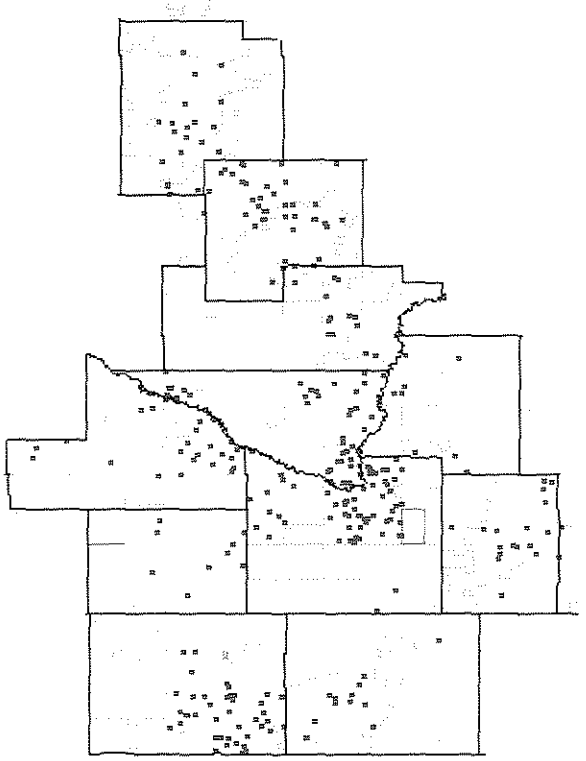


Exhibit III.B.7(e)
Density Map of All FFS Primary Providers in the South Central Region



Exhibits III.B.7(f) and III.B.7(g) on the following pages further illustrate that the ratio of FFS members to FFS primary care providers is sufficient in the South Central Region with the exception of Le Sueur and Sibley Counties, each of which are designated "low availability" counties when only Active FFS providers are considered. But when all FFS providers are considered (bottom map in Exhibit III.B.7(f)), each county changes to medium availability status. Faribault and Meeker Counties change to high availability status if managed care primary care providers are included (Exhibit III.B.7(g)).

Although the South Central Region's ratio of Active FFS providers to total FFS providers (48%) is greater than the statewide ratio (44%), six of the 11 counties in the South Central Region have ratios below the statewide figure. These include Brown (39%), Faribault (26%), Le Sueur (33%), Sibley (20%), Waseca (18%) and Watonwan (31%). Further details are shown in Exhibit III.B.7(h) which appears on page 63. This low participation among FFS primary care providers translates into lower office visit utilization in four of the six counties (refer to Exhibit III.B.7(i) on the same page). Brown, Sibley, Waseca and Watonwan Counties each have office visit utilization per 1,000 FFS members much below the region average and the statewide average. Faribault and Le Sueur Counties are near the region average and slightly below the statewide average. ER utilization is also low in Brown, Sibley and Waseca Counties. But these counties, similar to counties in the Southwest Region with low primary care availability but low ER utilization, have members who received a higher number of in-hospital evaluations or consultations than other counties in the state.

In general, most counties in the South Central Region have FFS members utilizing office visits and ER visits at or below the statewide average.

Exhibit III.B.7(f)
Comparison of FFS Members per Active Primary Provider and All Primary Providers in the South Central Region

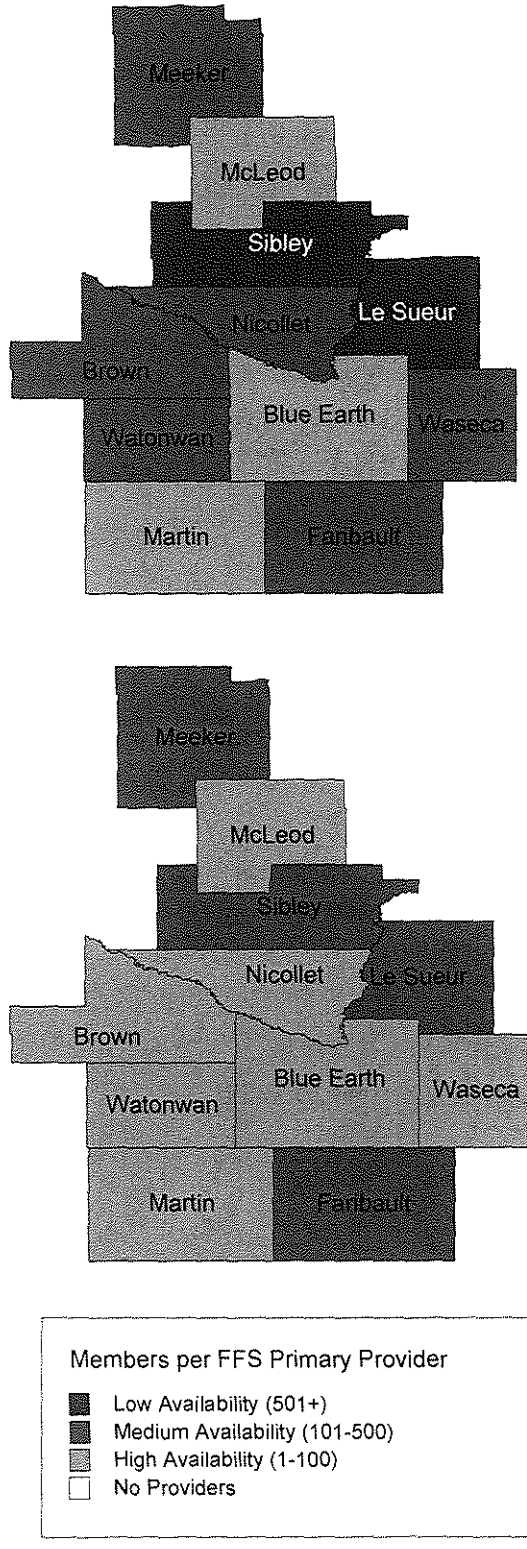


Exhibit III.B.7(g)
Comparison of FFS Members per All Medicaid FFS and Managed Care Primary Providers in the South Central Region

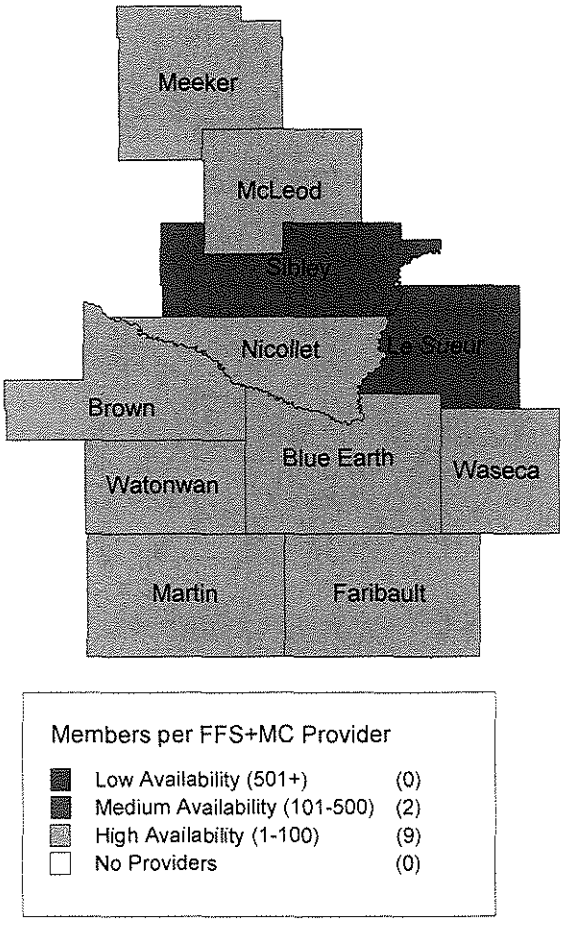


Exhibit III.B.7(h)
Summary of Potential Primary Care Provider Availability for Medicaid FFS Members in the South Central Region

	Quartile FFS Enrollment	FFS Providers			Managed Care Providers	Total Primary Care Providers	Percent Active FFS Primary Care Providers
		Active	Limited	Inactive			
Region		**214**	**44**	**99**	**91**	**448**	**48%**
Blue Earth	Mid-High	79	15	25	20	139	57%
Brown	Mid-Low	18	10	10	8	46	39%
Faribault	Mid-High	5	2	5	7	19	26%
Le Sueur	Mid-Low	3	0	5	1	9	33%
McLeod	Lowest	37	3	7	5	52	71%
Martin	Highest	27	4	10	15	56	48%
Meeker	Mid-Low	11	2	3	5	21	52%
Nicollet	Mid-High	21	3	8	14	46	46%
Sibley	Lowest	2	1	6	1	10	20%
Waseca	Mid-Low	6	3	12	13	34	18%
Watonwan	Mid-High	5	1	8	2	16	31%

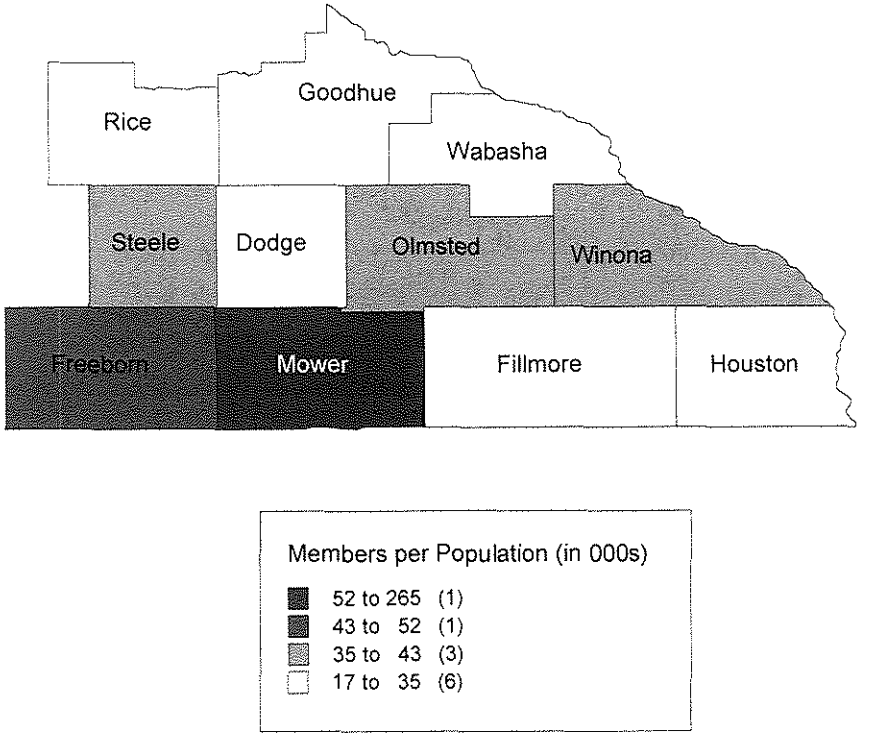
Exhibit III.B.7(i)
Primary Care Utilization for Medicaid FFS Members in the South Central Region

		Pct of Services Utilized by Members from Primary Care Providers					
	Level of Access to Active FFS Providers	Office Visits	ER Visits	Other Hospital Visits	Other	Office Visits per 1,000 FFS Enrollees	ER Visits per 1,000 FFS Enrollees
Statewide		**50%**	**8%**	**13%**	**29%**	**1,600**	**255**
Region		**53%**	**7%**	**10%**	**30%**	**1,360**	**184**
Blue Earth	High	53%	3%	9%	35%	1,530	80
Brown	Medium	44%	10%	16%	30%	655	142
Faribault	Medium	58%	10%	8%	23%	1,478	263
Le Sueur	Low	50%	9%	10%	31%	1,389	242
McLeod	High	51%	10%	9%	29%	1,629	331
Martin	High	60%	12%	12%	16%	1,592	316
Meeker	Medium	55%	6%	9%	30%	1,576	167
Nicollet	Medium	54%	5%	9%	31%	1,505	145
Sibley	Low	50%	8%	14%	28%	952	153
Waseca	Medium	48%	5%	13%	34%	806	86
Watonwan	Medium	48%	12%	10%	31%	951	237

Southeast Region

The Southeast Region is comprised of 11 counties and represents 9.3% of the total state population. Medicaid FFS enrollment is similar at 8.6% of the statewide enrollment. Most counties in the region, however, have lower FFS membership proportional to their population. Mower and Freeborn Counties weight the overall region higher. This is shown in Exhibit III.B.8(a).

Exhibit III.B.8(a)
July 2007 FFS Members per July 2007 Census Estimate



There is a significantly higher FFS primary care provider base in the Southeast Region when compared to FFS enrollment (the region has 19.5% of all statewide FFS providers), specifically around Rochester. The participation among these providers, however, is proportionally the lowest of all of the regions in the state.

Exhibit III.B.8(b)
Medicaid FFS Primary Care Provider Base in the Southeast Region

	Active	Limited	Inactive	Total
Southeast Providers	451	422	880	1,753
Percent of Total	26%	24%	50%	100%
Distribution Statewide	55%	16%	29%	100%

In the Southeast Region, Olmsted County has the highest concentration of FFS members (see exhibit below). But there is little difference between the number of Active FFS Primary Care providers and total FFS Primary Care providers in the county, and there may be gaps in availability here (refer to Exhibits III.B.8(d) and (e) on the next page). This may be a concern in light of the fact that Dodge County to the west has only one provider available to members. Fillmore County also suffers from a lack of available primary care providers even though there are FFS members spread throughout the county.

Exhibit III.B.8(c)
Density Map of Unduplicated FFS Members in the Southeast Region
1 Dot = 50 FFS Members

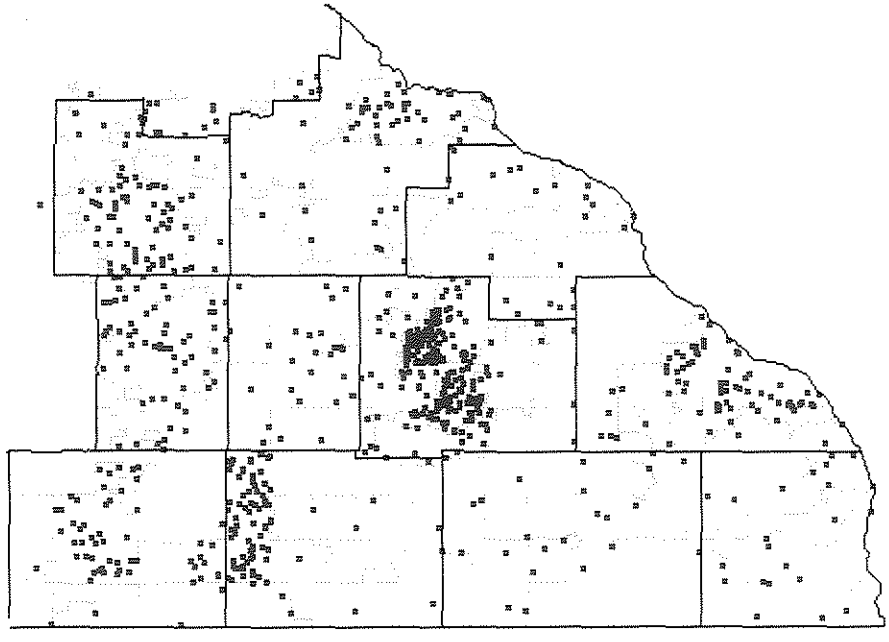


Exhibit III.B.8(d)
Density Map of Active FFS Primary Providers in the Southeast Region

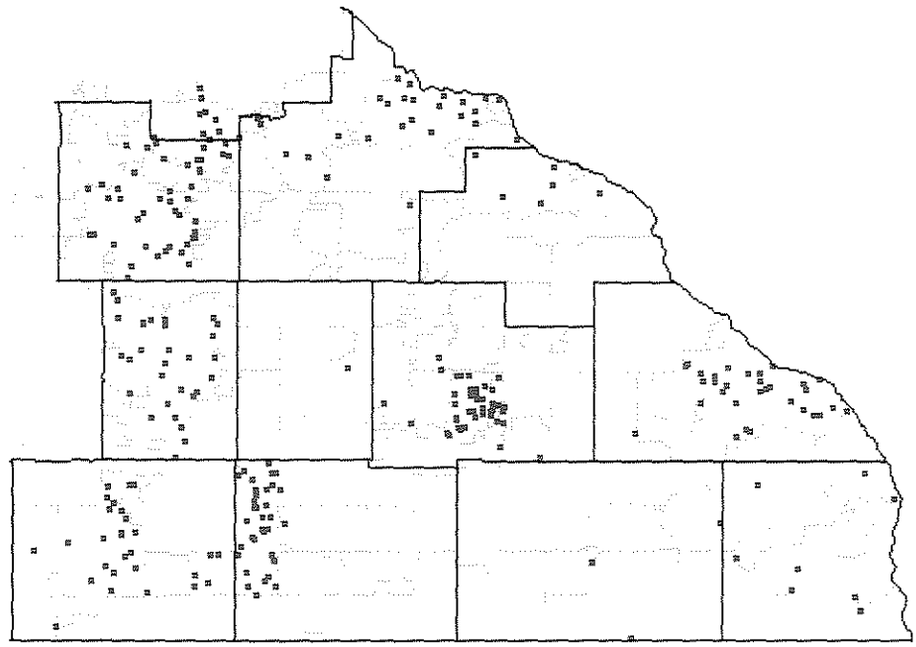
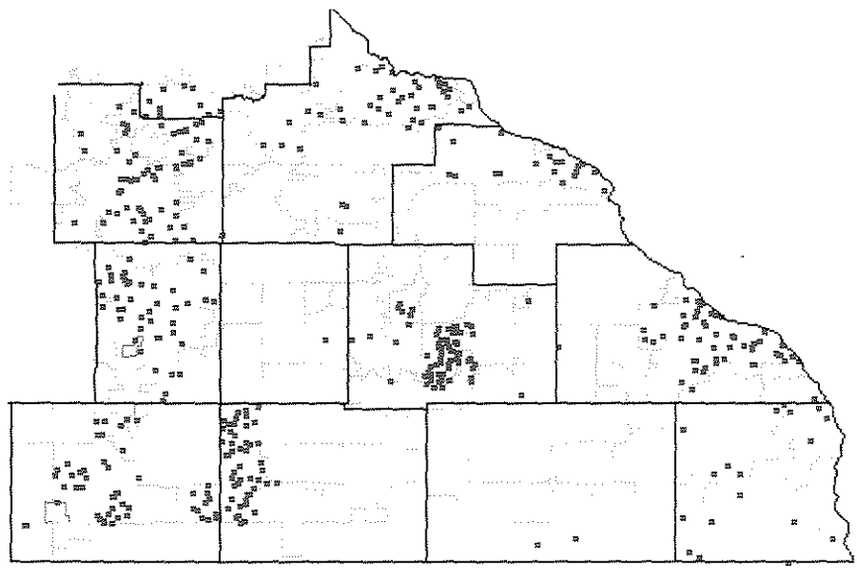


Exhibit III.B.8(e)
Density Map of All FFS Primary Providers in the Southeast Region



Exhibits III.B.8(f) and III.B.8(g) on the following pages further illustrate that the ratio of FFS members to FFS primary care providers is sufficient in the Southeast Region with the exception of Dodge and possibly Fillmore Counties. Each county, however, is in the lowest quartile among counties in the state based on the percentage of FFS members. Even when managed care primary care providers are included (Exhibit III.B.8(g)), Dodge County remains a low availability county and Fillmore remains a medium availability county.

The Southeast Region's ratio of Active FFS providers to total FFS providers (20%) is the lowest in the state, but this is weighted by the low ratio in Olmsted County. In fact, only three of the 11 counties have ratios below the statewide ratio (44%). These include Houston (36%), Olmsted (13%) and Wabasha (21%) Counties. Further details are shown in Exhibit III.B.8(h) which appears on page 70. This low participation among FFS primary care providers translates into lower office visit utilization only in Wabasha County (893 visits per 1,000 FFS enrollees versus the region average of 1,393 per 1,000). All of the counties in the Southeast Region have lower office visit utilization per 1,000 than the statewide average (1,600 per 1,000) to some degree (refer to Exhibit III.B.8(i) on the same page). By the same token, the counties with the highest office visit utilization per 1,000 also have the highest ER utilization per 1,000. This implies that FFS members in the Southeast Region are not substituting the ER for office visits. Rice County is the only county in the region that has ER utilization significantly higher (554 per 1,000 members) than the statewide average (255 per 1,000).

Exhibit III.B.8(f)
Comparison of FFS Members per Active Primary Provider and All Primary Providers in the Southeast Region

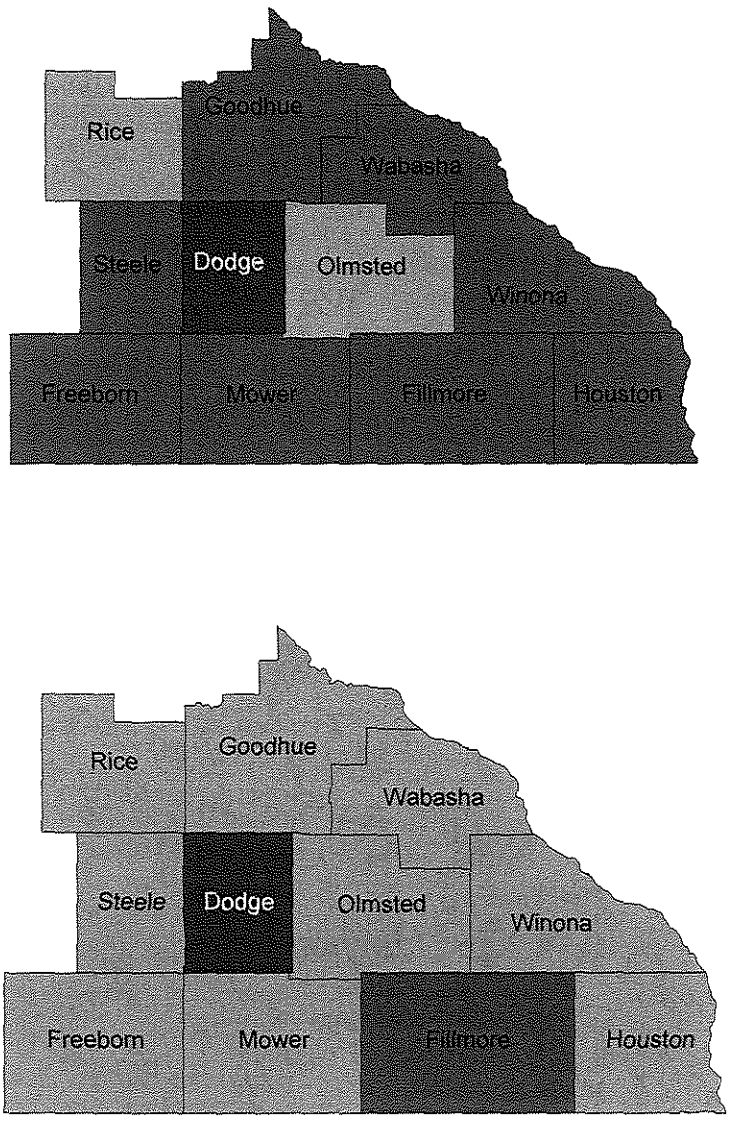


Exhibit III.B.8(g)
Comparison of FFS Members per All Medicaid FFS and Managed Care Primary Providers in the Southeast Region

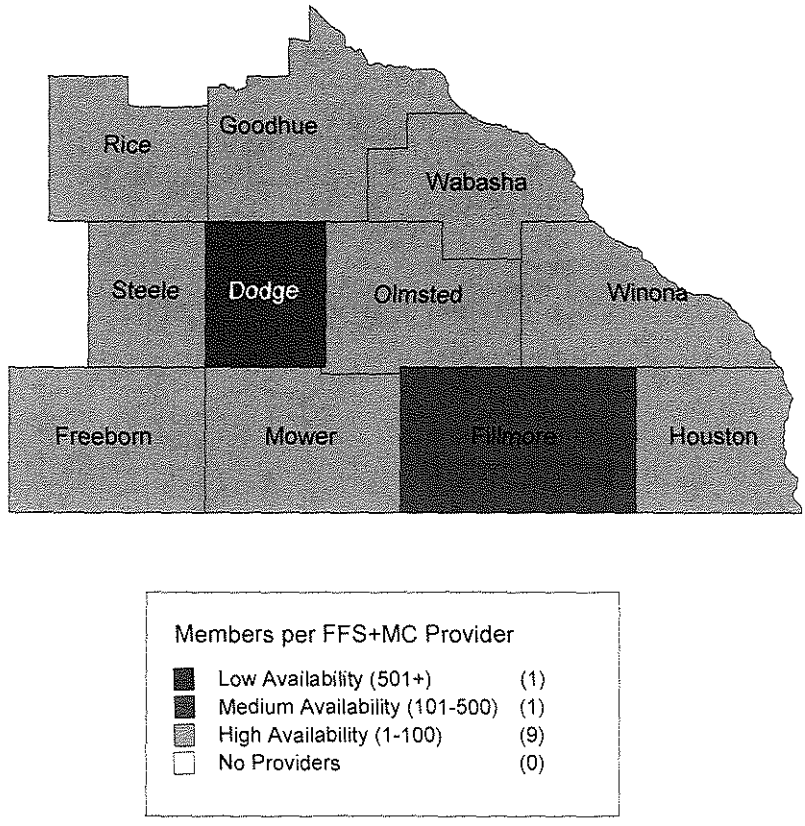


Exhibit III.B.8(h)
Summary of Potential Primary Care Provider Availability for Medicaid FFS Members in the Southeast Region

	Quartile FFS Enrollment	FFS Providers			Managed Care Providers	Total Primary Care Providers	Percent Active FFS Primary Care Providers
		Active	Limited	Inactive			
Region		**451**	**422**	**880**	**466**	**2,219**	**20%**
Dodge	Lowest	1	0	0	0	1	100%
Fillmore	Lowest	4	1	1	3	9	44%
Freeborn	Mid-High	28	7	14	15	64	44%
Goodhue	Lowest	26	9	8	13	56	46%
Houston	Lowest	8	2	7	5	22	36%
Mower	Highest	34	10	5	15	64	53%
Olmsted	Mid-Low	230	368	806	371	1,775	13%
Rice	Lowest	52	6	10	17	85	61%
Steele	Mid-Low	31	5	7	11	54	57%
Wabasha	Lowest	6	4	12	7	29	21%
Winona	Mid-Low	31	10	10	9	60	52%

Exhibit III.B.8(i)
Primary Care Utilization for Medicaid FFS Members in the Southeast Region

		Pct of Services Utilized by Members from Primary Care Providers					
	Level of Access to Active FFS Providers	Office Visits	ER Visits	Other Hospital Visits	Other	Office Visits per 1,000 FFS Enrollees	ER Visits per 1,000 FFS Enrollees
Statewide		**50%**	**8%**	**13%**	**29%**	**1,600**	**255**
Region		**50%**	**12%**	**10%**	**28%**	**1,393**	**328**
Dodge	Low	52%	9%	8%	32%	1,205	199
Fillmore	Medium	56%	7%	13%	25%	1,380	167
Freeborn	Medium	54%	13%	9%	24%	1,447	344
Goodhue	Medium	51%	14%	12%	23%	1,458	384
Houston	Medium	55%	4%	5%	36%	1,542	100
Mower	Medium	51%	14%	13%	22%	1,258	341
Olmsted	High	52%	10%	10%	28%	1,412	271
Rice	High	47%	18%	9%	26%	1,485	554
Steele	Medium	46%	11%	7%	36%	1,578	373
Wabasha	Medium	31%	7%	14%	48%	893	197
Winona	Medium	50%	13%	9%	27%	1,329	352

Section III.C: Statewide Results for Selected Specialists

B&A selected six specialist providers that are highly utilized by Medicaid FFS populations nationally to measure the availability of care that Minnesota's FFS enrollees have to these specialties. Each specialist is displayed in a statewide map on the following pages to determine the level of availability of Minnesota's FFS population. The specialties include:

- Exhibit III.C.1: OB/GYNs (only female FFS members are measured for availability)
- Exhibit III.C.2: Psychiatrists
- Exhibit III.C.3: Dentists
- Exhibit III.C.4: Cardiologists
- Exhibit III.C.5: Neurologists
- Exhibit III.C.6: Orthopedic Surgeons

From an urban/rural perspective, in general there is sufficient availability of each specialist type in the urban areas of the state and limited to no availability in the rural regions. The one exception is for dentists where availability is spread evenly among most counties and only three counties do not have dentists available to FFS members.

B&A examined the cities with populations greater than 60,000 citizens based on the latest census data available. The table below is a summary of the findings shown on Exhibits III.C.1 through III.C.6 for the urban regions in the state.

		Level of Availability to Each Specialist in the Urban Area					
City/Cities	**County**	**OB/GYN**	**Psych.**	**Dentist**	**Cardiology**	**Neurology**	**Ortho**
Duluth	St. Louis	Medium	Medium	Medium	High	High	High
St. Cloud	Stearns	Medium	Medium	Medium	High	High	High
Rochester	Olmstead	High	High	Medium	High	High	High
Coon Rapids	Anoka	Medium	Medium	Medium	Medium	Medium	Medium
Twin Cities*	Hennepin, Ramsey, Dakota	Medium	Medium	Medium	Medium to High	Medium to High	Medium to High

*Includes Bloomington, Brooklyn Park, Burnsville, Minneapolis, Eagan, Plymouth, St. Paul

Conversely, availability of care is low to nonexistent in rural areas of the state (table below excludes the seven counties listed above).

Specialist Type	**Counties with Availability**	**Counties with Low Availability**	**Counties with No Availability**
OB/GYN	34	6	40
Psychiatrist	18	20	42
Dentist	67	10	3
Cardiologist	4	1	75
Neurologist	4	9	67
Orthopedic Surgeon	29	6	45

Exhibit III.C.1
Female Fee-for-Service Members per OB/GYN, By County

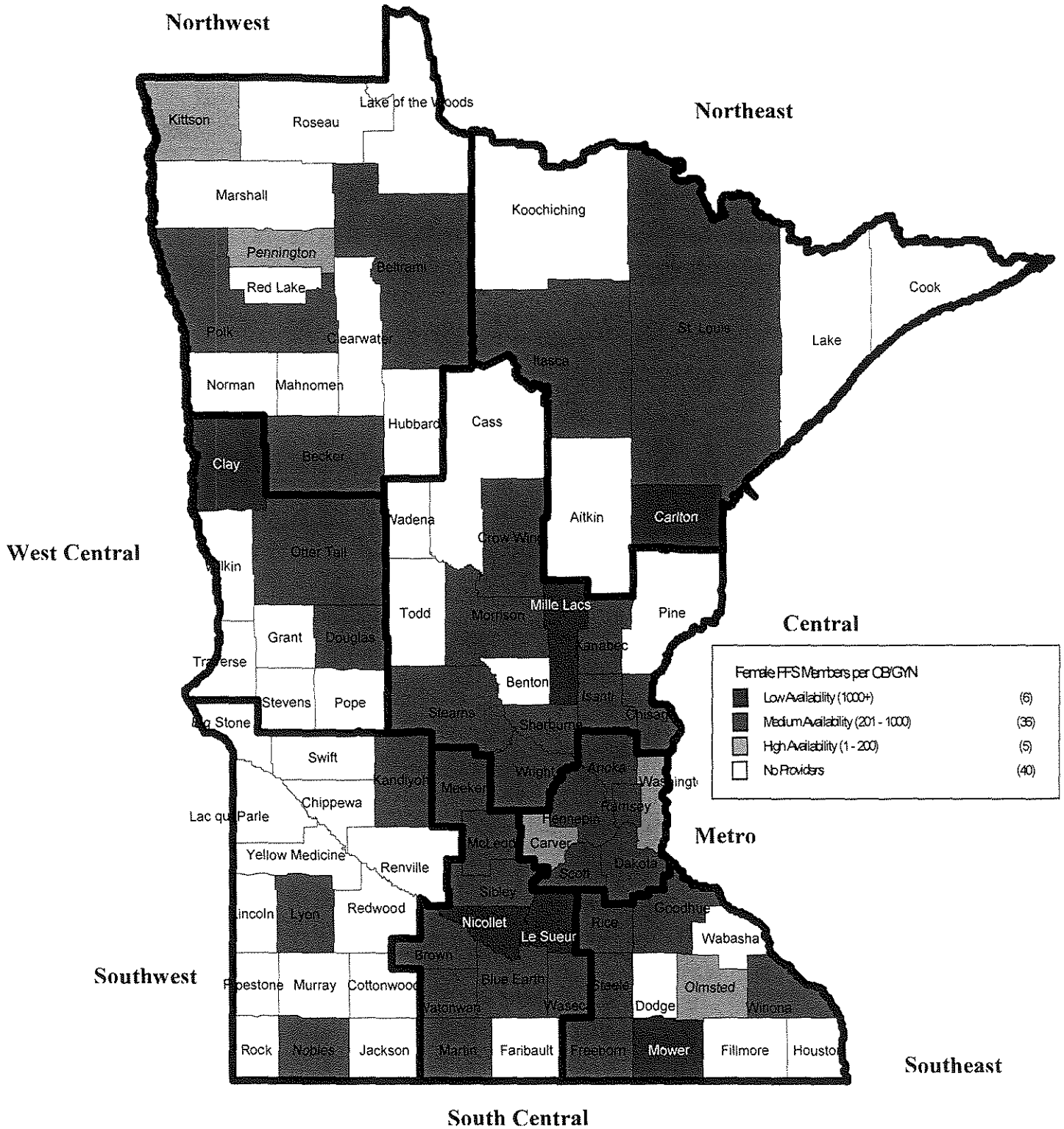


Exhibit III.C.2
Fee-for-Service Members per Psychiatrist, By County

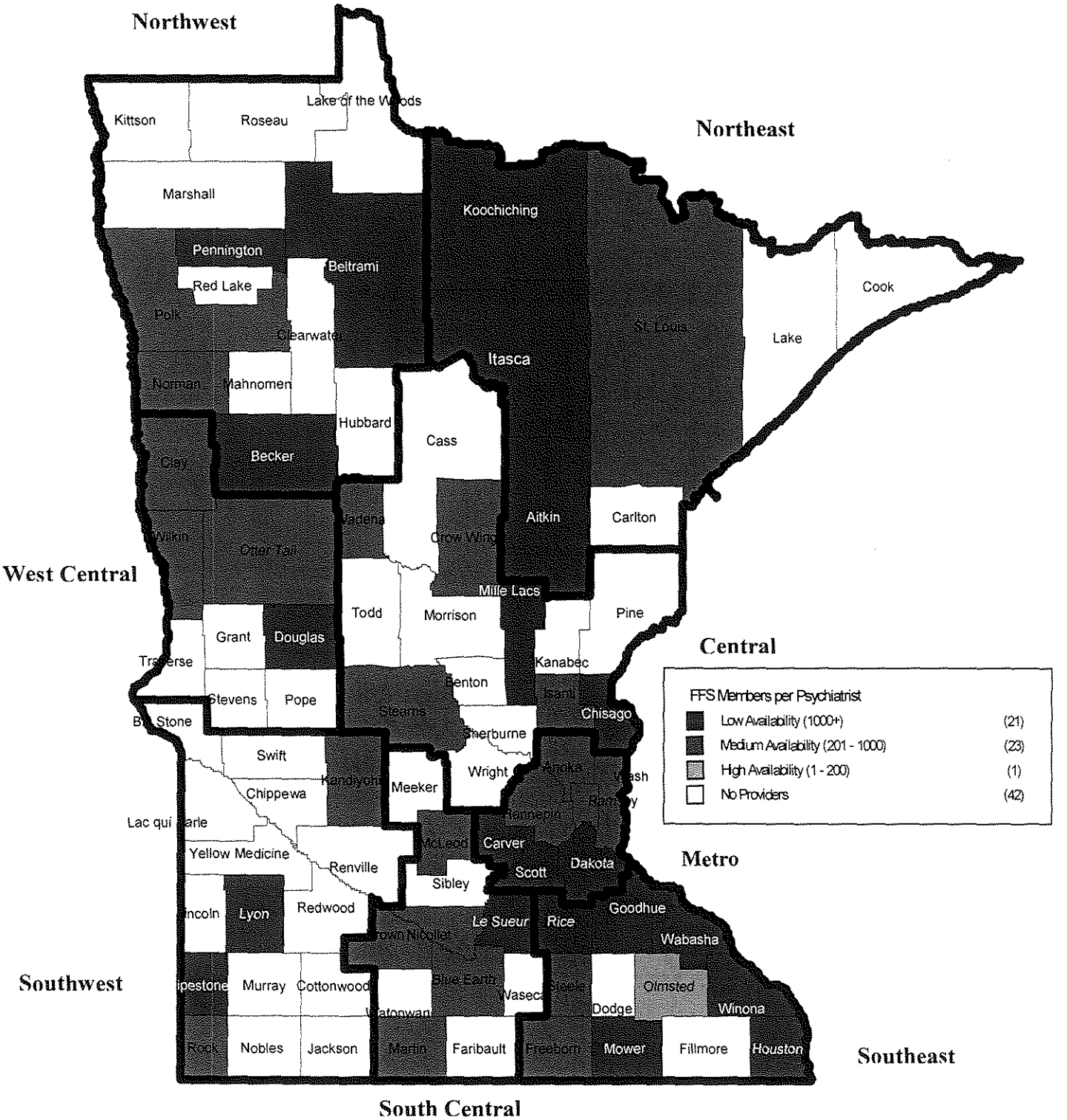


Exhibit III.C.3
Fee-for-Service Members per Dentist, By County

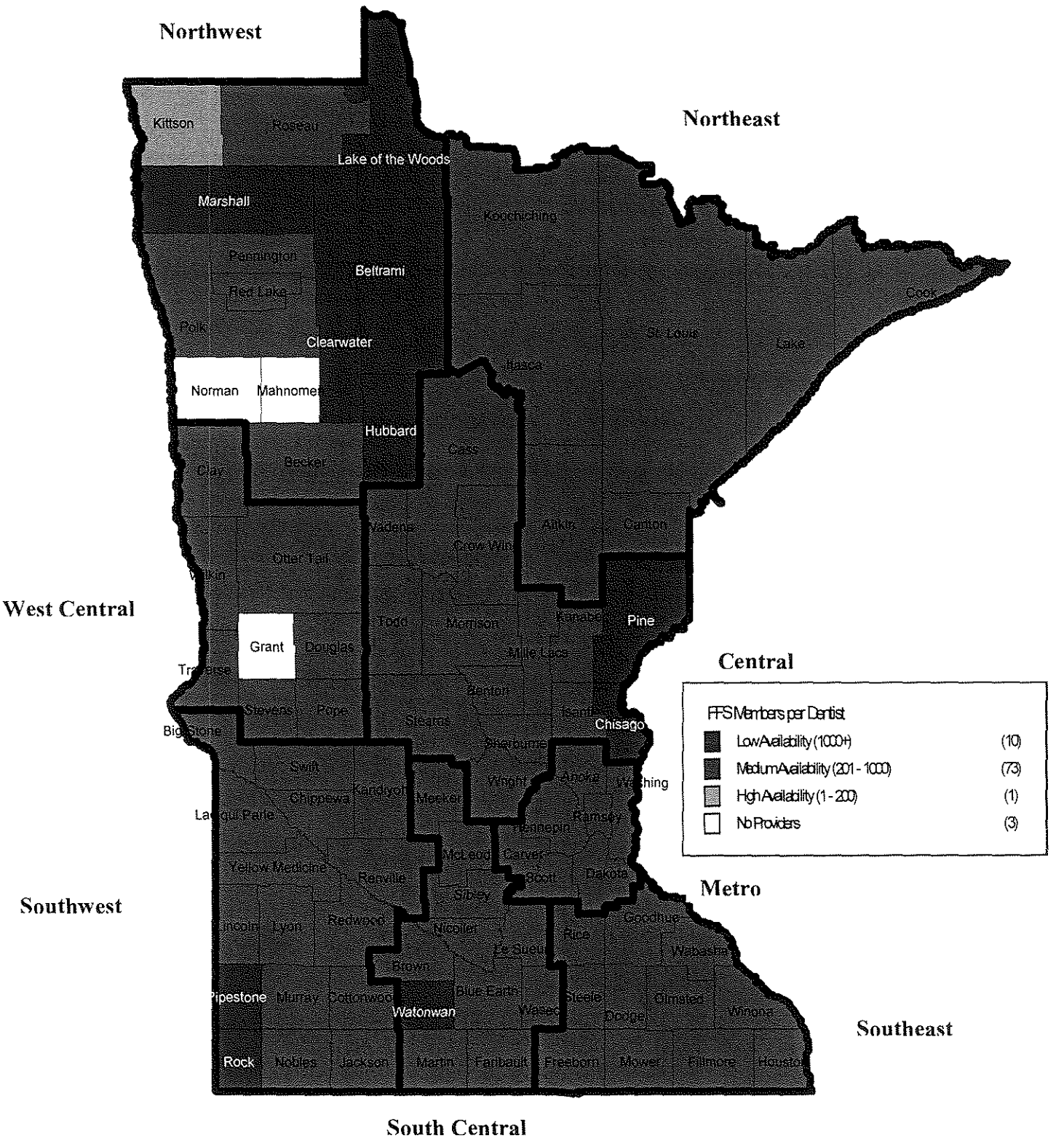


Exhibit III.C.4
Fee-for-Service Members per Cardiologist, By County

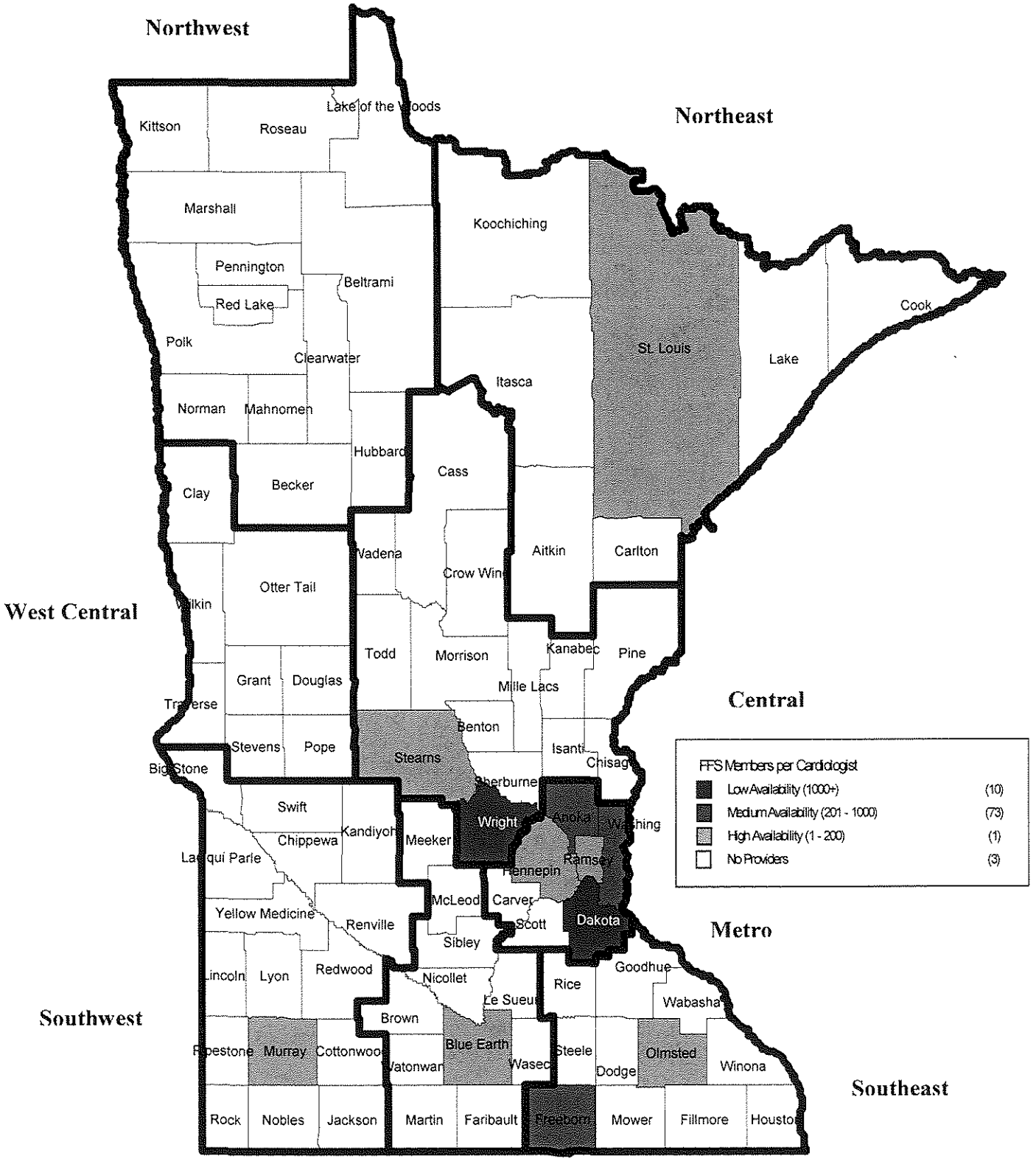


Exhibit III.C.5
Fee-for-Service Members per Neurologist, By County

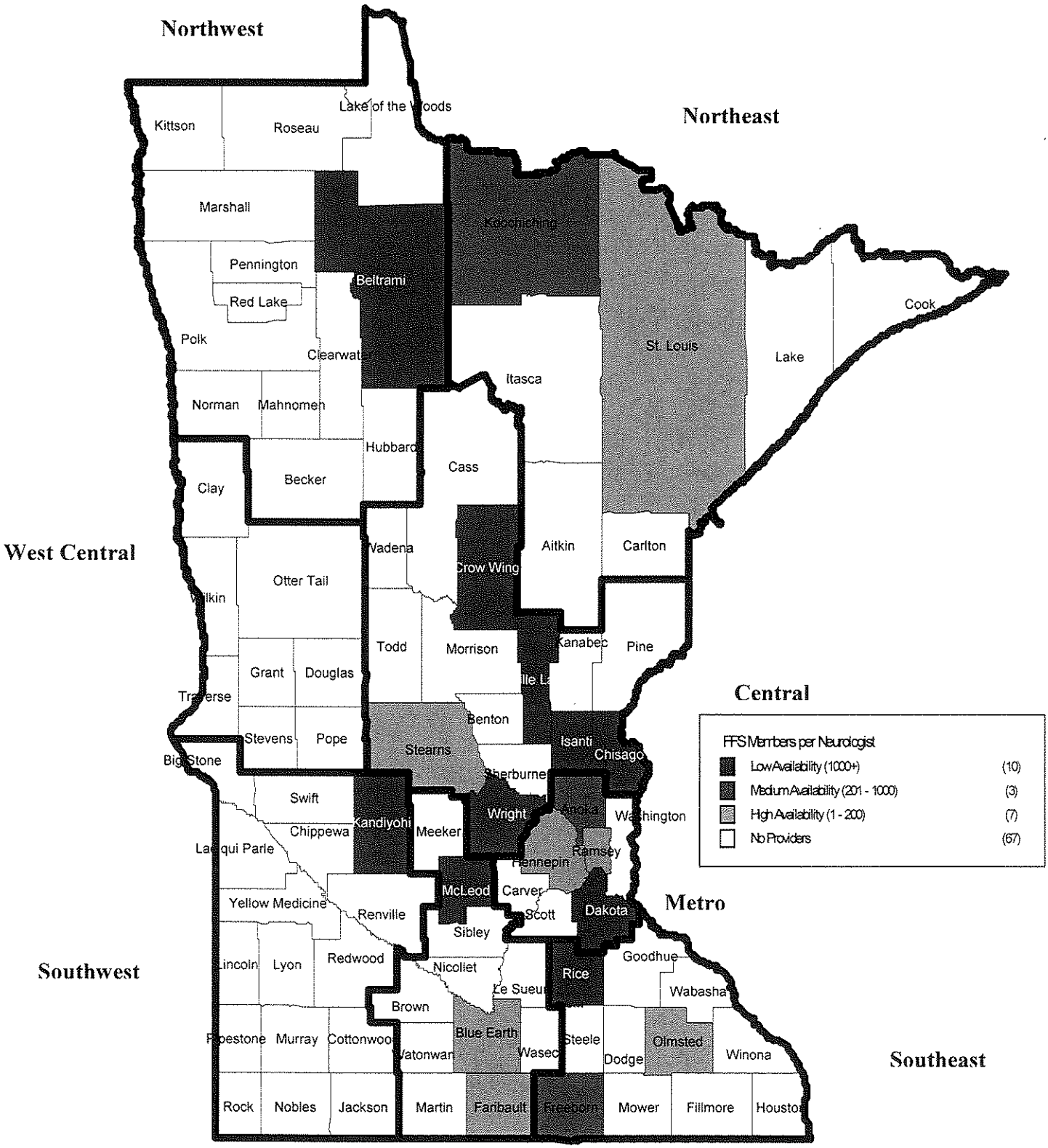
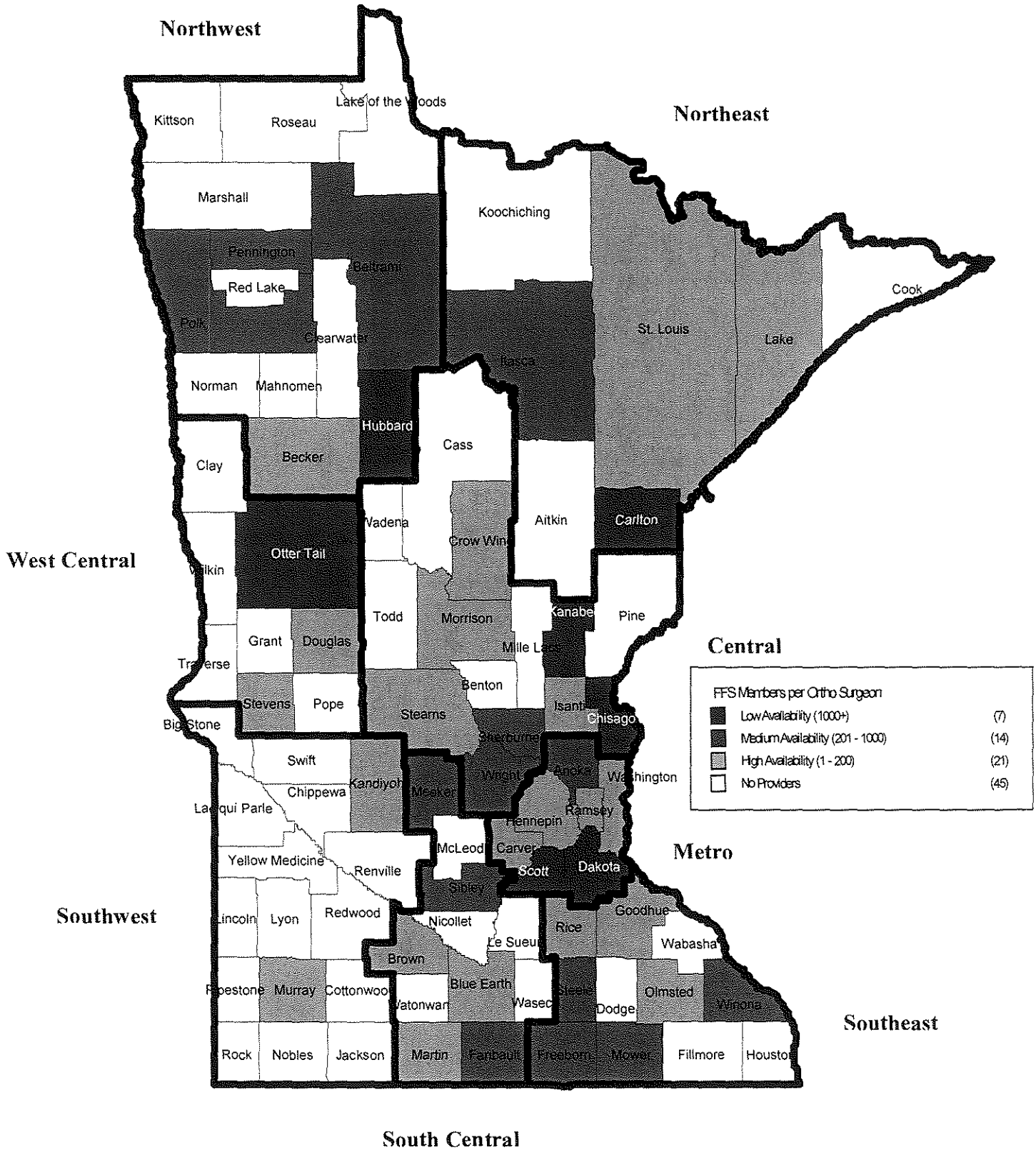


Exhibit III.C.6
Fee-for-Service Members per Orthopedic Surgeon, By County



Section III.D: Results for Selected Specialists by Region

Section III.D presents data about availability of specialists and utilization of specialist services in each of the eight regions. Each subsection below presents findings in a consistent format for each region.

- Findings with accompanying exhibits related to OB/GYNs
- Findings with accompanying exhibits related to Psychiatrists
- Findings with accompanying exhibits related to Dentists
- Findings of utilization related to Cardiologists, Neurologists and Orthopedic Surgeons in light of the fact that so few counties have these specialists located in their counties

Northwest Region

OB/GYNs

In the Northwest Region, eight of the 13 counties in the region do not have an OB/GYN available to serve female FFS members (see Exhibit III.D.1(a) below). For the other five counties, Becker, Beltrami and Polk Counties have medium level availability (defined as 200-1,000 members per OB/GYN) and Kittson and Pennington have high availability (defined as under 200 members per OB/GYN). Refer to Exhibit III.D.1(b) on the next page.

Exhibit III.D.1(a)
Density Map of OB/GYNs in the Northwest Region

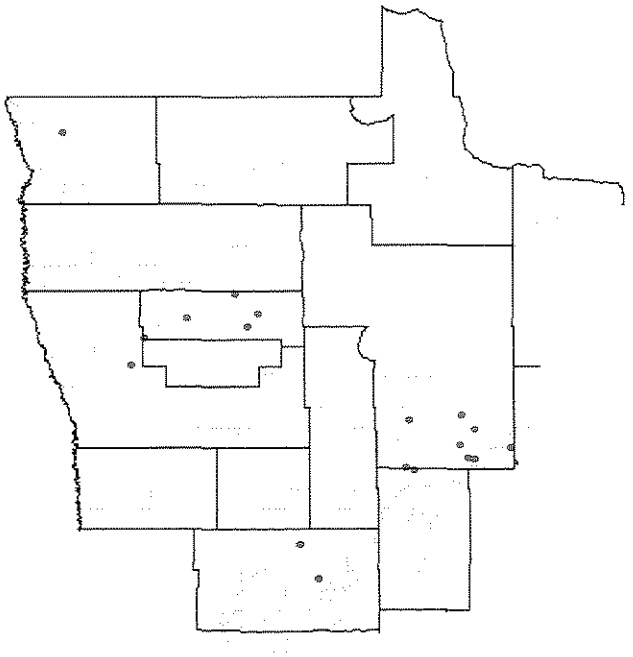
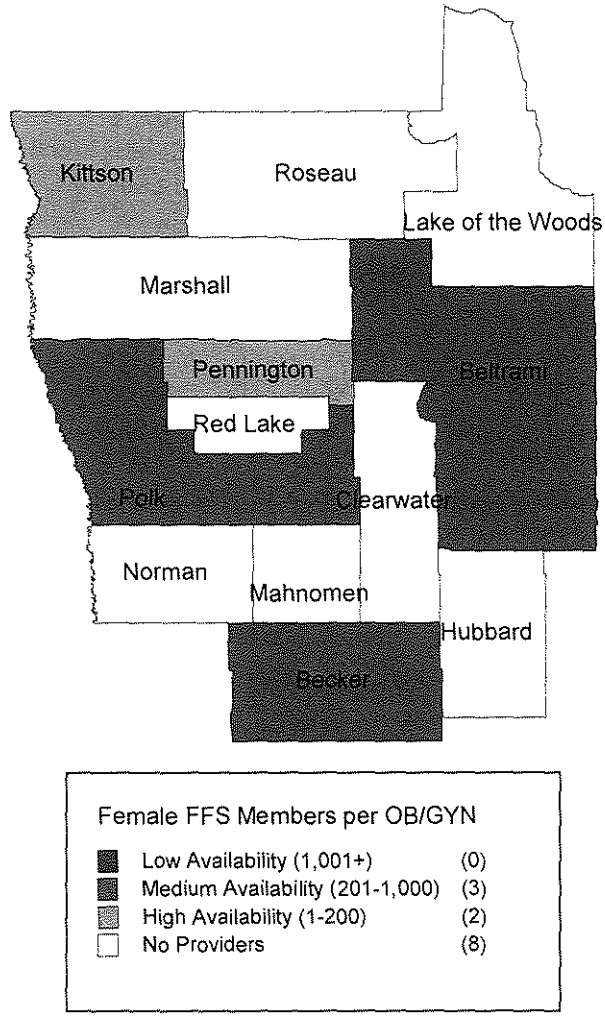


Exhibit III.D.1(b)
Comparison of Female FFS Members per OB/GYN in the Northwest Region



Despite the lack of providers, women in most counties are accessing services at a rate similar to or greater than the statewide average. When measuring the ratio of visits per 1,000 female FFS enrollees (to control for differences in the number of members in each county), the Northwest Region as a whole had visits of 708 per 1,000 versus the statewide ratio of 594 visits per 1,000. Like the analysis of primary care visits, the findings reported here include services delivered to the FFS members over the entire 24-month period of State Fiscal Years 2007 and 2008.

The noticeable differences at the county level are Lake of the Woods and Roseau Counties, each with substantially lower utilization (167 and 117, respectively) than the region average. For the other counties where there is limited to no availability, this means that the members in these counties are seeking OB/GYN services in counties where providers are present. (In Red Lake County, OB/GYN services may be accessed at Indian Health facilities.) Refer to Exhibit III.D.1(c) below for county-specific results.

Exhibit III.D.1(c)
OB/GYN Utilization for Female Medicaid FFS Members in the Northwest Region

	Level of Availability of OB/GYNs	Visits per 1,000 Female FFS Enrollees
Statewide		**594**
Region		**708**
Becker	Medium	720
Beltrami	Medium	842
Clearwater	No Provider	637
Hubbard	No Provider	596
Kittson	High	732
Lake of the Woods	No Provider	167
Mahnomen	No Provider	782
Marshall	No Provider	739
Norman	No Provider	444
Pennington	High	1,167
Polk	Medium	448
Red Lake	No Provider	521
Roseau	No Provider	117

Psychiatrists

Eight of the 13 counties in the Northwest Region do not have a psychiatrist available to FFS members (see Exhibit III.D.1(d) below). Becker, Beltrami and Pennington Counties have low availability, while Norman and Polk Counties have medium availability (see Exhibit III.D.1(e)).

Exhibit III.D.1(d)
Density Map of Psychiatrists in the Northwest Region

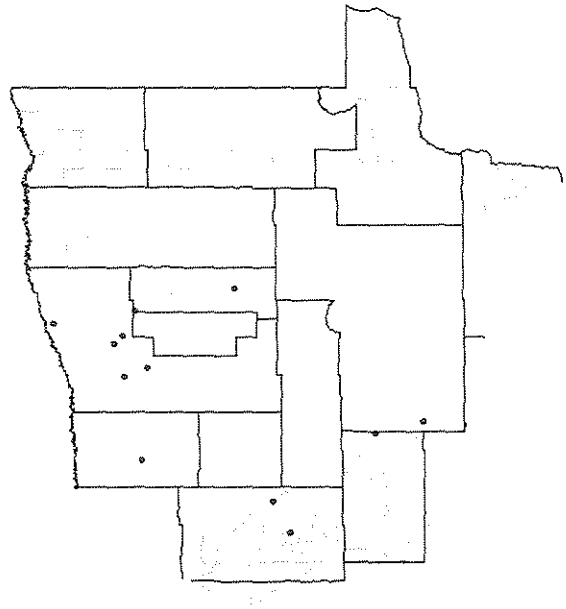
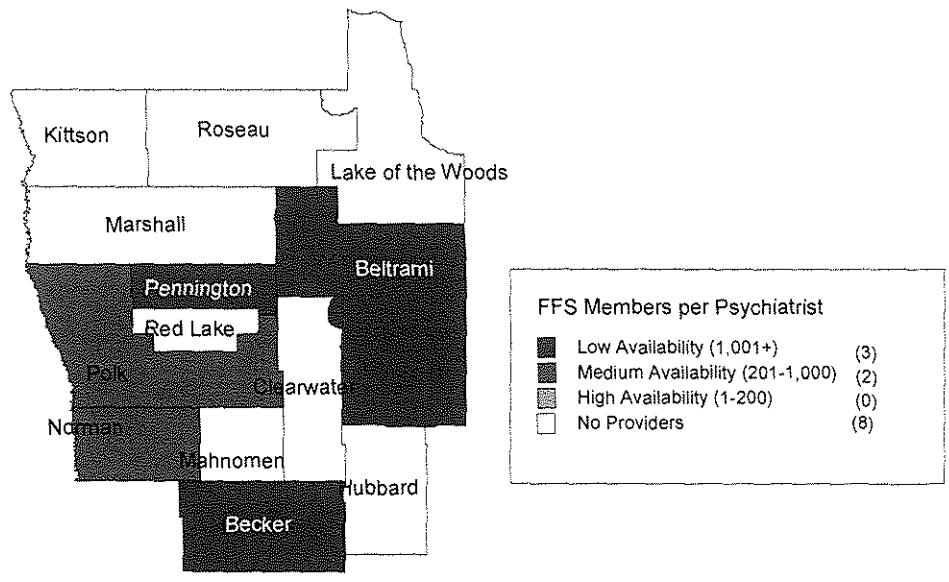


Exhibit III.D.1(e)
Comparison of FFS Members per Psychiatrist in the Northwest Region



FFS members in the counties where there is no psychiatrist present are less likely to utilize psychiatrist services. The entire Northwest Region had lower utilization than the statewide average (315 visits per 1,000 versus 433 visits per 1,000 statewide). With the exception of Mahnomen and Marshall Counties, the Northwest Counties with no psychiatrist also had much lower utilization on a per 1,000 member basis (see Exhibit III.D.1(f) below).

Exhibit III.D.1(f)
Psychiatrist Utilization for Medicaid FFS Members in the Northwest Region

	Level of Availability of Psychiatrists	Visits per 1,000 FFS Enrollees
Statewide		**433**
Region		**315**
Becker	Low	472
Beltrami	Low	285
Clearwater	No Provider	231
Hubbard	No Provider	178
Kittson	No Provider	187
Lake of the Woods	No Provider	273
Mahnomen	No Provider	408
Marshall	No Provider	349
Norman	Medium	404
Pennington	Low	263
Polk	Medium	466
Red Lake	No Provider	129
Roseau	No Provider	130

Dentists

There is at least one dentist available to FFS members in every county in the Northwest Region except for Norman and Mahnomen Counties (see Exhibit III.D.1(g) below). These are two of three counties in the state with no dentists for the FFS program. Additionally, five counties—Lake of the Woods, Marshall, Baltrami, Clearwater and Hubbard—have low availability. Kittson County has high availability relative to the number of FFS enrollees in the county (see Exhibit III.D.1(h) on the next page).

Exhibit III.D.1(g)
Density Map of Dentists in the Northwest Region

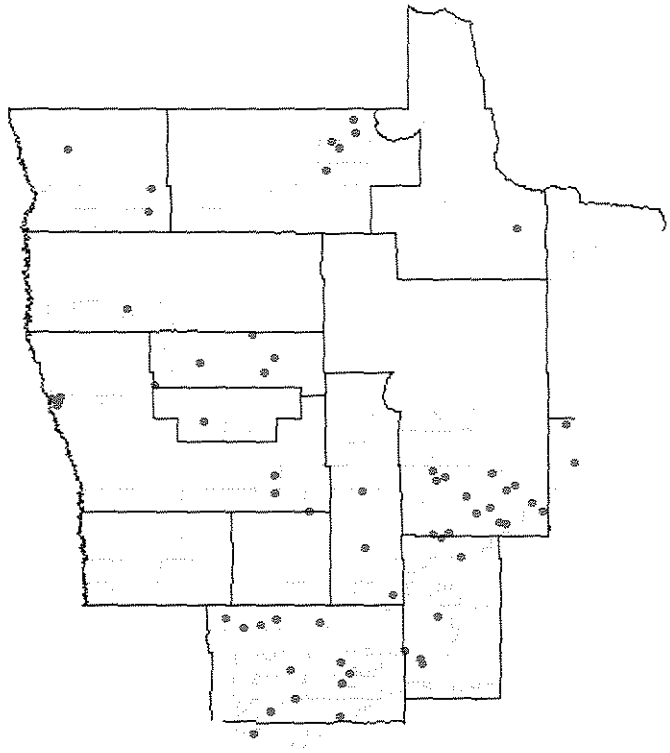
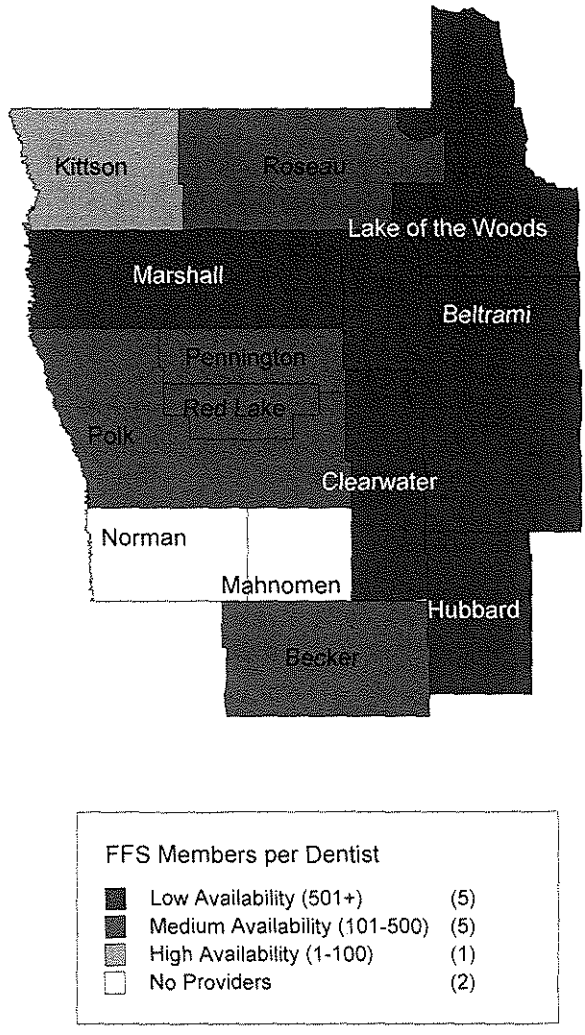


Exhibit III.D.1(h)
Comparison of FFS Members per Dentist in the Northwest Region



Despite this, four of the five counties with low availability levels had members with higher dental visits than the statewide average. The Northwest Region as a whole has higher dental utilization (856 visits per 1,000 FFS members) than the statewide average (743 visits per 1,000) for the two-year period examined. Clearwater, Hubbard, and Lake of the Woods in particular had very high dental utilization. This means that FFS members in many cases are accessing dental providers outside of their home county to obtain services. County-specific results are shown in Exhibit III.D.1(i) on the next page.

Exhibit III.D.1(i)
Dentist Utilization for Medicaid FFS Members in the Northwest Region

	Level of Availability of Dentists	Visits per 1,000 FFS Enrollees
Statewide		**743**
Region		**856**
Becker	Medium	719
Beltrami	Low	802
Clearwater	Low	1,394
Hubbard	Low	1,462
Kittson	High	809
Lake of the Woods	Low	1,520
Mahnomen	No Provider	553
Marshall	Low	576
Norman	No Provider	601
Pennington	Medium	762
Polk	Medium	614
Red Lake	Medium	500
Roseau	Medium	619

Cardiologists, Neurologists and Orthopedic Surgeons

There is not a clear indication that the absence of cardiologists, neurologists or orthopedic surgeons in a county implies that FFS members are not accessing these services outside of their home county. In the Northwest region, for example, there is only one county that has a neurologist (Beltrami) and only three that have orthopedic surgeons (Beltrami, Pennington and Polk). No counties have a cardiologist. Yet availability is not significantly higher for FFS members in the counties where these specialists are located (see Exhibit III.D.1(j) below). In fact, three counties (Kittson, Mahnomen and Norman) have cardiologist utilization higher than the statewide average even though there are no cardiologists present in the county. For neurology, Clearwater, Mahnomen and Polk Counties are at or near the statewide utilization despite no providers present. For orthopedic surgeons, six counties have utilization higher than the statewide average, but only two of them (Beltrami and Pennington) have an orthopedic surgeon available in the county.

Exhibit III.D.1(j)
Utilization for Medicaid FFS Members in the Northwest Region Among Other Specialists

	Provider Specialty Located in County?			Claims Per 1,000 FFS Enrollees		
	Cardiologist	Neurologist	Orthopedic Surgeon	Cardiologist	Neurologist	Orthopedic Surgeon
Statewide				**162**	**121**	**127**
Region				**116**	**110**	**151**
Becker	No	No	No	124	116	152
Beltrami	No	Yes	Yes	114	111	175
Clearwater	No	No	No	56	128	155
Hubbard	No	No	No	56	94	131
Kittson	No	No	No	232	64	52
Lake of the Woods	No	No	No	104	50	118
Mahnomen	No	No	No	172	129	123
Marshall	No	No	No	128	97	96
Norman	No	No	No	230	117	106
Pennington	No	No	Yes	105	110	121
Polk	No	No	Yes	155	120	157
Red Lake	No	No	No	119	78	146
Roseau	No	No	No	91	72	59

Northeast Region

OB/GYNs

In the Northeast Region, four of the seven counties do not have an OB/GYN available to serve female FFS members (see Exhibit III.D.2(a) below). In the other three counties, Carlton has low availability while Itasca and St. Louis Counties have medium availability see Exhibit III.D.2(b) on the next page).

Lack of or low availability of OB/GYNs does not directly correlate to lower availability in the Northeast Region. St. Louis and Lake Counties each have higher OB/GYN utilization among female FFS enrollees than the statewide average, even though Lake County has no OB/GYN providers. Enrollees are most likely accessing services in St. Louis County. But there does appear to be a relationship between availability and utilization in Aitkin and Koochiching Counties. Both counties have no OB/GYN provider and both have much lower utilization rates than other counties in the region or in the state (refer to Exhibit III.D.2(c) on the next page).

Exhibit III.D.2(a)
Density Map of OB/GYNs in the Northeast Region

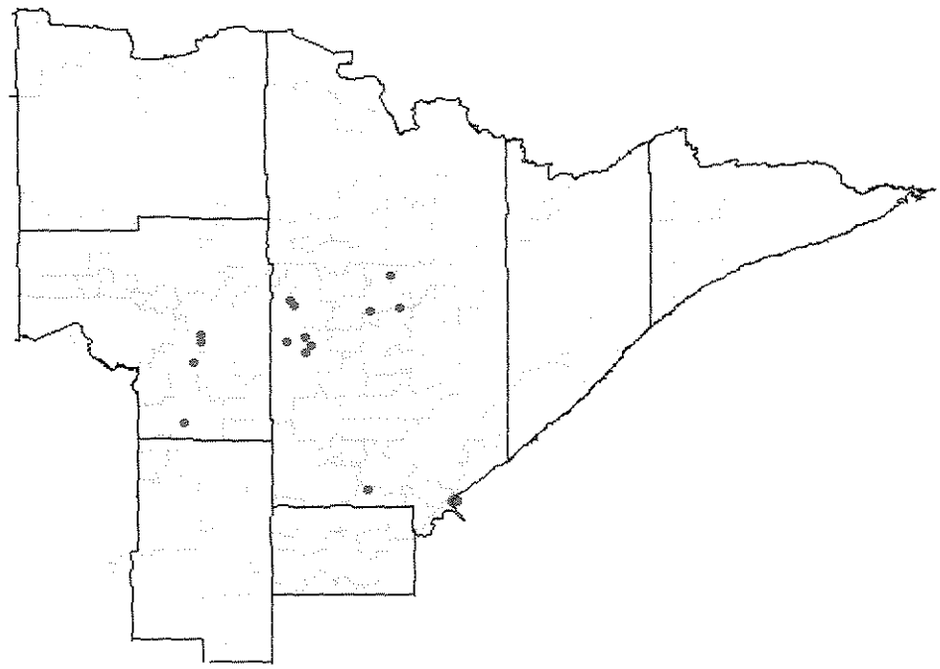
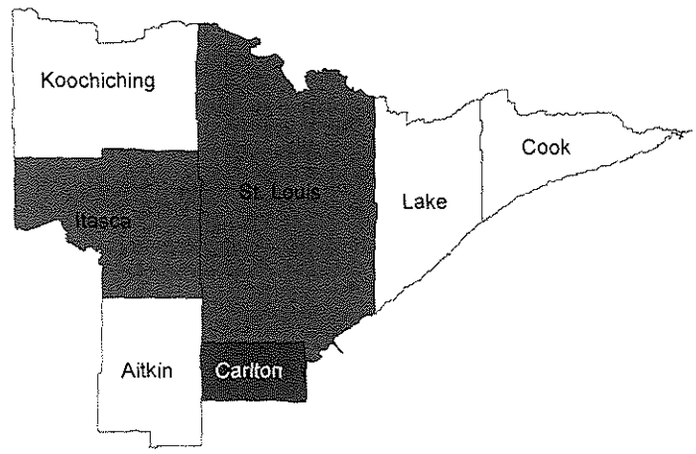


Exhibit III.D.2(b)
Comparison of Female FFS Members per OB/GYN in the Northeast Region



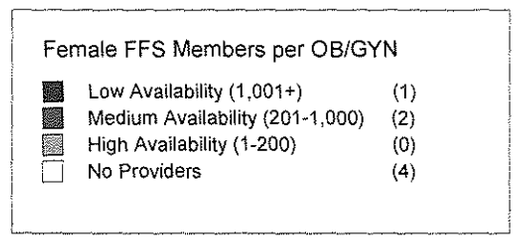


Exhibit III.D.2(c)
OB/GYN Utilization for Female Medicaid FFS Members in the Northeast Region

	Level of Availability of OB/GYNs	Visits per 1,000 Female FFS Enrollees
Statewide		**594**
Region		**550**
Aitkin	No Provider	226
Carlton	Low	435
Cook	No Provider	433
Itasca	Medium	363
Koochiching	No Provider	279
Lake	No Provider	624
St. Louis	Medium	644

Psychiatrists

Other than in St. Louis County, availability to psychiatrists in the Northeast Region is very limited. Four of the seven counties do not have a psychiatrist available and Koochiching County only has one (see Exhibit III.D.2(d) below). Aitkin and Itasca Counties also have low availability while St. Louis County has medium availability (see Exhibit III.D.2(e) on the next page).

Utilization of psychiatrist services is mixed and does not correlate to provider availability at the county level (refer to Exhibit III.D.2(e) on the next page). The region average of 538 visits per 1,000 FFS members is higher than the statewide average (433 visits per 1,000). But this appears to be driven by the utilization in Itasca (low availability county), Koochiching (low availability county) and St. Louis (medium availability county) Counties. Other counties with no availability or low availability show utilization below the statewide average.

Exhibit III.D.2(d)
Density Map of Psychiatrists in the Northeast Region

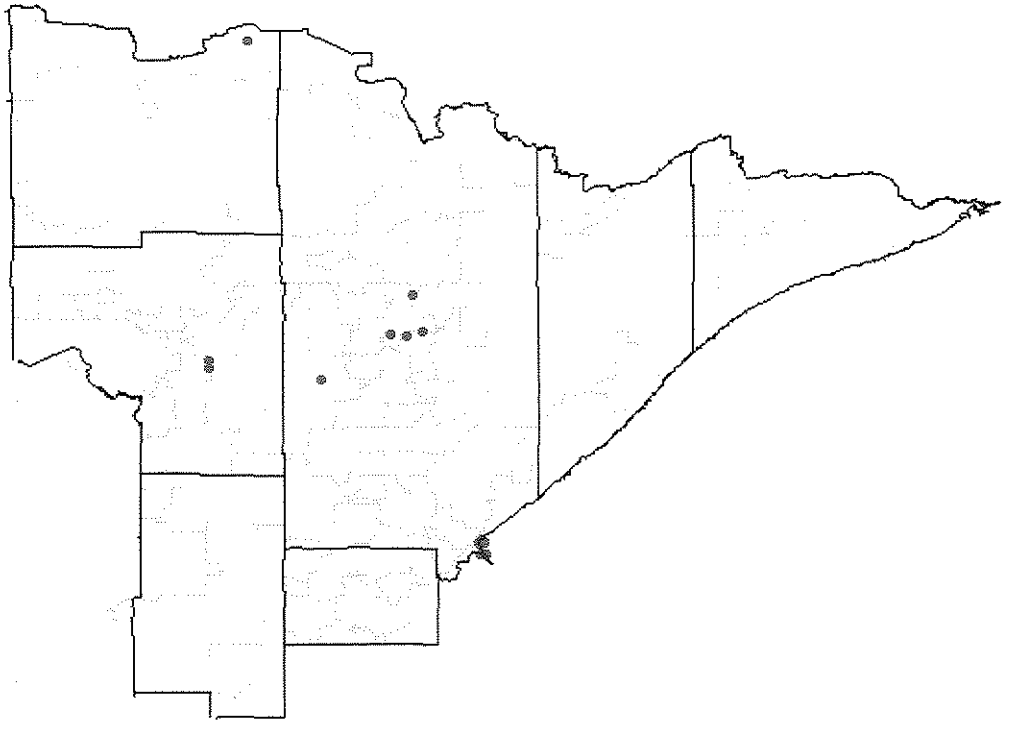


Exhibit III.D.2(e)
Comparison of FFS Members per Psychiatrist in the Northeast Region

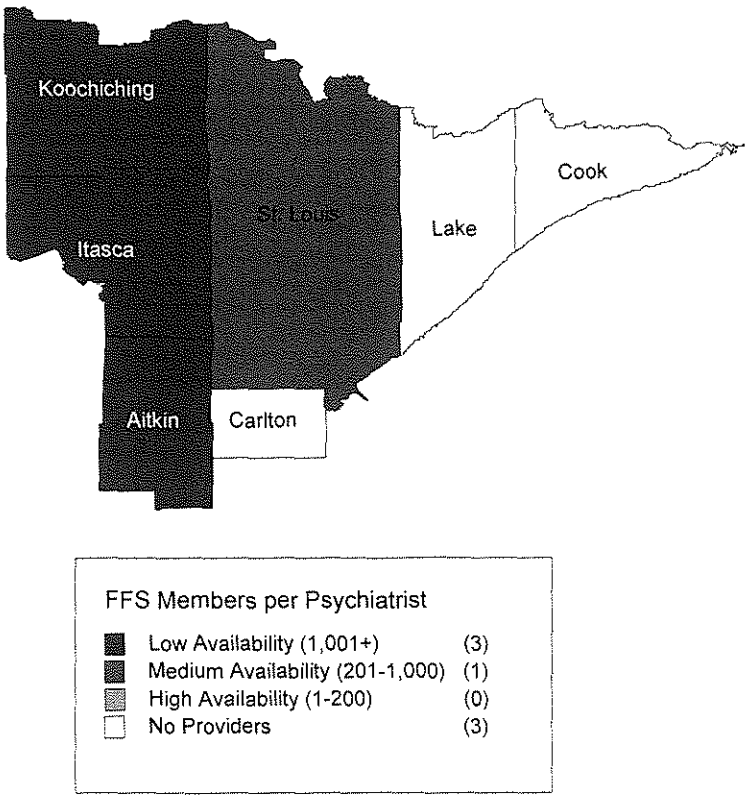


Exhibit III.D.2(f)
Psychiatrist Utilization for Medicaid FFS Members in the Northeast Region

	Level of Availability of Psychiatrists	Visits per 1,000 FFS Enrollees
Statewide		**433**
Region		**538**
Aitkin	Low	224
Carlton	No Provider	417
Cook	No Provider	230
Itasca	Low	553
Koochiching	Low	678
Lake	No Provider	396
St. Louis	Medium	576

Dentists

There are dentists available in every county in the Northeast Region, but are limited in Koochiching, Lake and Cook Counties (see Exhibit III.D.2(g) below). Measured as the number of dentists per FFS member, however, each county in the region is designated as medium availability (see Exhibit III.D.2(h) on the next page).

This level of availability correlates to higher utilization as well. Each of the counties in the Northeast Region has higher utilization (measured per 1,000 FFS members) than the statewide average. The region average of 926 visits per 1,000 over the two-year period studied is significantly higher than the statewide average of 743 visits per 1,000. Refer to Exhibit III.D.2(i) on the next page for more details.

Exhibit III.D.2(g)
Density Map of Dentists in the Northeast Region

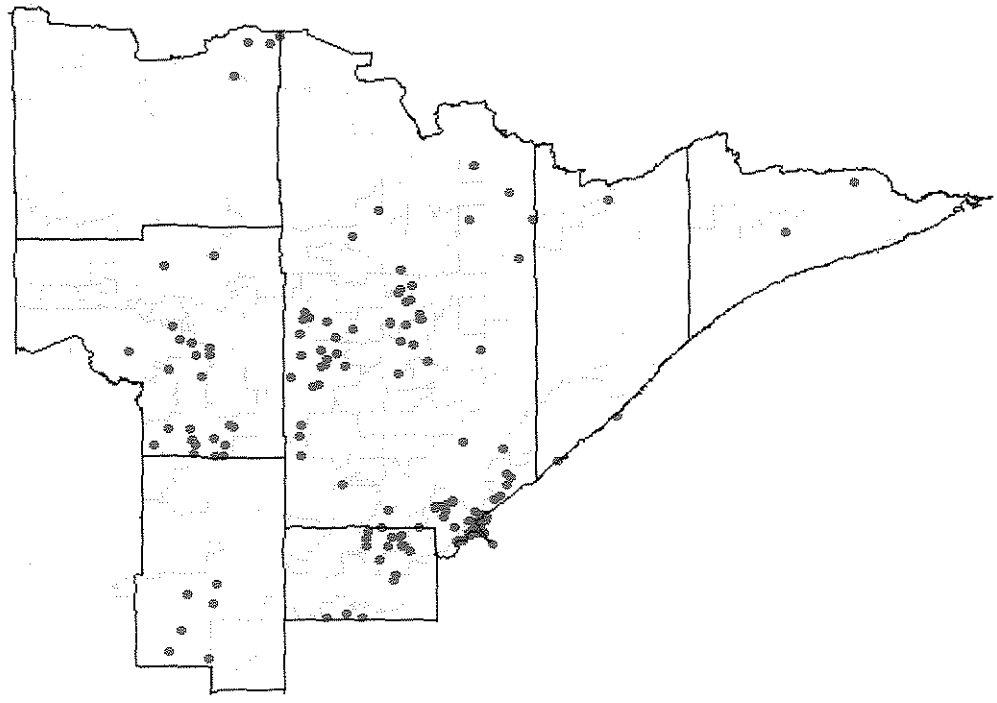
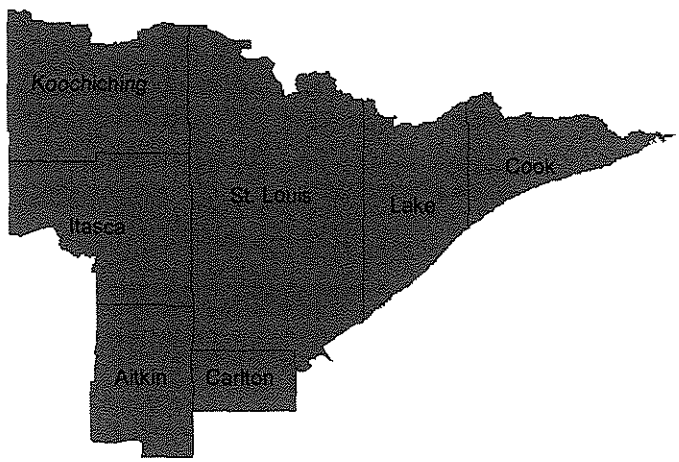


Exhibit III.D.2(h)
Comparison of FFS Members per Dentist in the Northeast Region



FFS Members per Dentist	
Low Availability (501+)	(0)
Medium Availability (101-500)	(7)
High Availability (1-100)	(0)
No Providers	(0)

Exhibit III.D.2(i)
Dentist Utilization for Medicaid FFS Members in the Northeast Region

	Level of Availability of Dentists	Visits per 1,000 FFS Enrollees
Statewide		**743**
Region		**926**
Aitkin	Medium	986
Carlton	Medium	1,055
Cook	Medium	892
Itasca	Medium	1,054
Koochiching	Medium	896
Lake	Medium	750
St. Louis	Medium	881

Cardiologists, Neurologists and Orthopedic Surgeons

There is not a clear indication that the absence of cardiologists, neurologists or orthopedic surgeons in a county implies that FFS members are not accessing these services outside of their home county. In the Northeast region, members in St. Louis and Lake Counties have higher utilization of cardiologists, neurologists and orthopedic surgeons than the statewide average (see Exhibit III.D.2(j) below). St. Louis County has each of these specialists available in the county and, most likely, Lake County enrollees also utilize these specialists. In other counties, cardiologist utilization is lower than the statewide average, and there is no cardiologist in any of these counties. But for neurology, three other counties (Aitkin, Carlton and Koochiching) have utilization above the statewide average even though only Koochiching County has a neurologist. For orthopedic surgeons, only Aitkin County is below the statewide utilization average.

Exhibit III.D.2(j)
Utilization for Medicaid FFS Members in the Northeast Region Among Other Specialists

	Provider Specialty Located in County?			Claims Per 1,000 FFS Enrollees		
	Cardiologist	Neurologist	Orthopedic Surgeon	Cardiologist	Neurologist	Orthopedic Surgeon
Statewide				**162**	**121**	**127**
Region				**154**	**153**	**144**
Aitkin	No	No	No	91	139	115
Carlton	No	No	Yes	102	132	131
Cook	No	No	No	141	104	249
Itasca	No	No	Yes	86	91	124
Koochiching	No	Yes	No	107	138	137
Lake	No	No	Yes	178	185	209
St. Louis	Yes	Yes	Yes	184	172	150

West Central Region

OB/GYNs

In the West Central Region, five of the eight counties do not have an OB/GYN available to serve female FFS members (see Exhibit III.D.3(a) below). In the other three counties, Clay has low availability while Douglas and Otter Tail have medium availability (see Exhibit III.D.3(b) on the next page).

Lack of or low availability of OB/GYNs does not directly correlate to lower availability in the West Central Region. Pope and Traverse Counties each have lower utilization per 1,000 female FFS members than the statewide average and they each do not have any OB/GYN providers in their counties. But the other three counties with no providers (Grant, Stevens and Wilkin) each have utilization at or near the statewide average. At the regional level, the West Central Region's OB/GYN utilization per 1,000 of 539 is only slightly lower than the statewide average of 594 (refer to Exhibit III.D.3(c) on the next page).

Exhibit III.D.3(a)
Density Map of OB/GYNs in the West Central Region

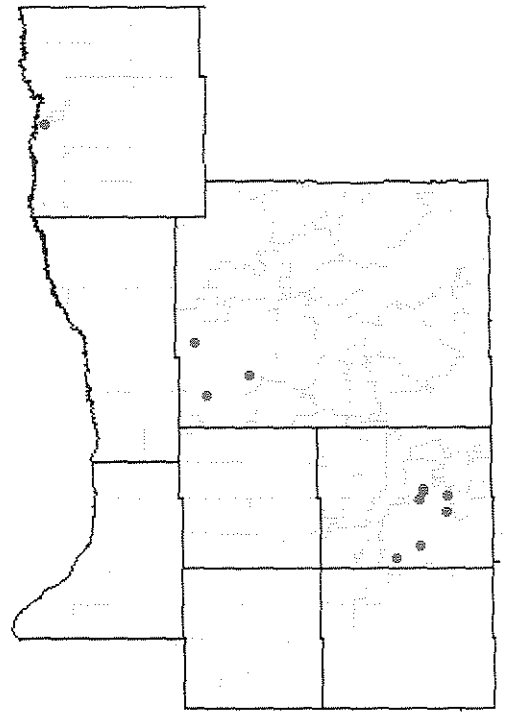


Exhibit III.D.3(b)
Comparison of Female FFS Members per OB/GYN in the West Central Region

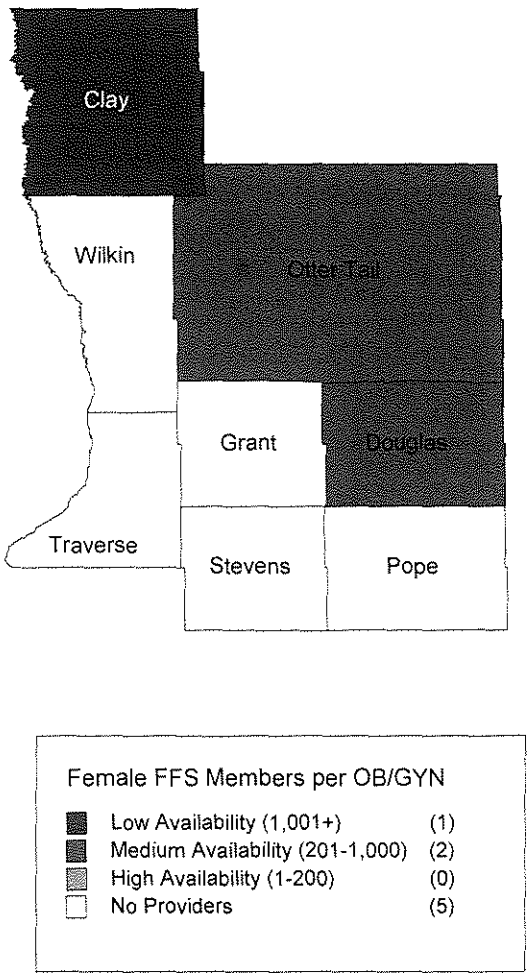


Exhibit III.D.3(c)
OB/GYN Utilization for Female Medicaid FFS Members in the West Central Region

	Level of Availability of OB/GYNs	Visits per 1,000 Female FFS Enrollees
Statewide		**594**
Region		**539**
Clay	Low	450
Douglas	Medium	566
Grant	No Provider	535
Otter Tail	Medium	647
Pope	No Provider	415
Stevens	No Provider	536
Traverse	No Provider	389
Wilkin	No Provider	490

Psychiatrists

Four of the eight counties in the West Central Region do not have a psychiatrist available and Douglas and Wilkin Counties only have one (see Exhibit III.D.3(d) below). Clay and Otter Tail Counties have medium availability (see Exhibit III.D.3(e) on the next page).

Other than Traverse County which has low psychiatrist utilization (230 visits per 1,000 FFS members), none of the other counties in the region have very low utilization despite the lack of providers (refer to Exhibit III.D.3(e) on the next page). Although many counties have utilization below the region average (540 per 1,000), they still have utilization near the statewide average (433 per 1,000). The utilization statistics measure the member's utilization regardless of the location where the service was received. These higher utilization figures imply that members in the West Central Region either utilize psychiatrist services in the areas of the region where providers are available or possibly with providers who contract with Minnesota's FFS program in North Dakota.

Exhibit III.D.3(d)
Density Map of Psychiatrists in the West Central Region

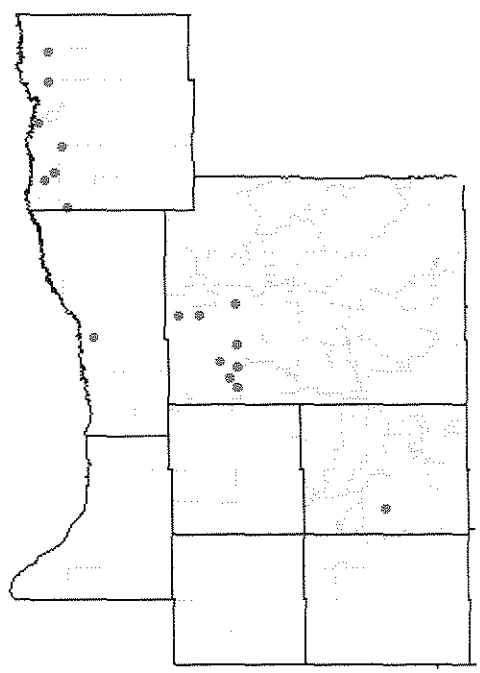


Exhibit III.D.3(e)
Comparison of FFS Members per Psychiatrist in the West Central Region

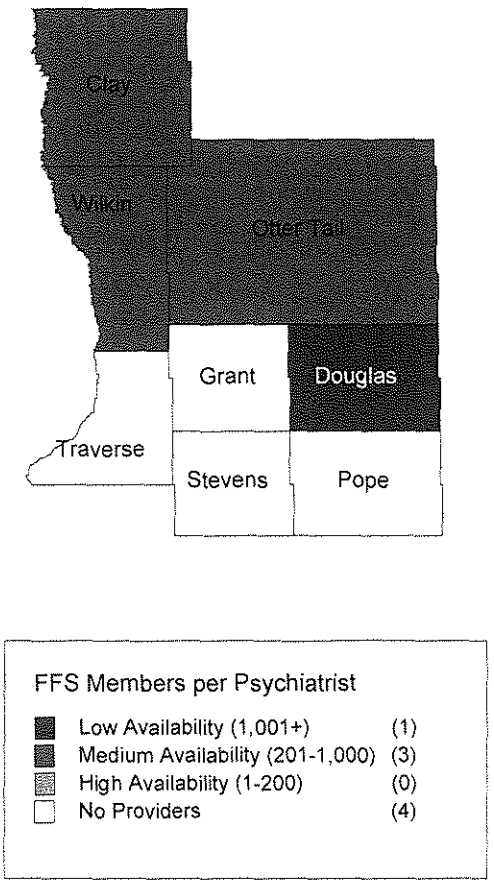


Exhibit III.D.3(f)
Psychiatrist Utilization for Medicaid FFS Members in the West Central Region

	Level of Availability of Psychiatrists	Visits per 1,000 FFS Enrollees
Statewide		**433**
Region		**540**
Clay	Medium	762
Douglas	Low	349
Grant	No Provider	383
Otter Tail	Medium	477
Pope	No Provider	365
Stevens	No Provider	774
Traverse	No Provider	230
Wilkin	Medium	409

Dentists

Grant County is one of three counties in the state where there are no dentists available to FFS enrollees (refer to Exhibit III.D.3(g) below). The other counties in the West Central Region all have medium availability when measuring the number of dentists to the number of FFS enrollees (refer to Exhibit III.D.3(h) on the next page).

Because dentist coverage appears to be adequate in the region, utilization of dental services in the West Central Region is, in fact, higher than the statewide average when measured on a per 1,000 FFS member basis (refer to Exhibit III.D.3(i) on the next page). However, it is interesting to note that Grant County—which does not have any dentists in the county—has one of the higher utilization ratios while Clay County—which has medium availability—has the lowest utilization ratio and is the only county in the region that is not above or near the statewide average.

Exhibit III.D.3(g)
Density Map of Dentists in the West Central Region

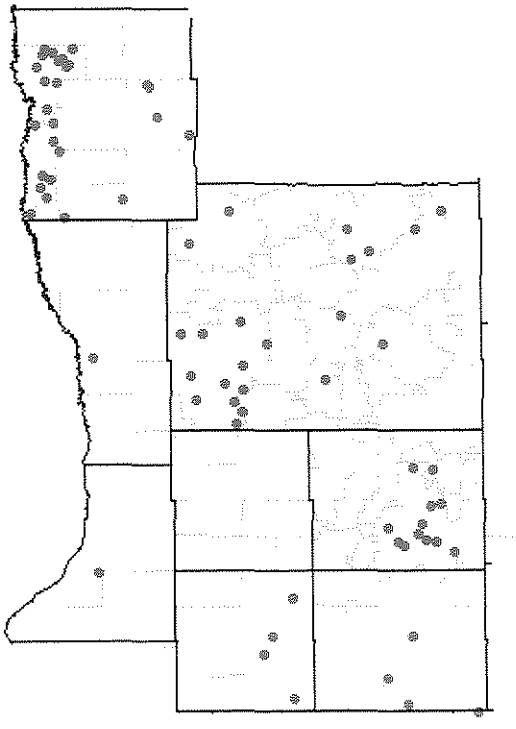


Exhibit III.D.3(h)
Comparison of FFS Members per Dentist in the West Central Region

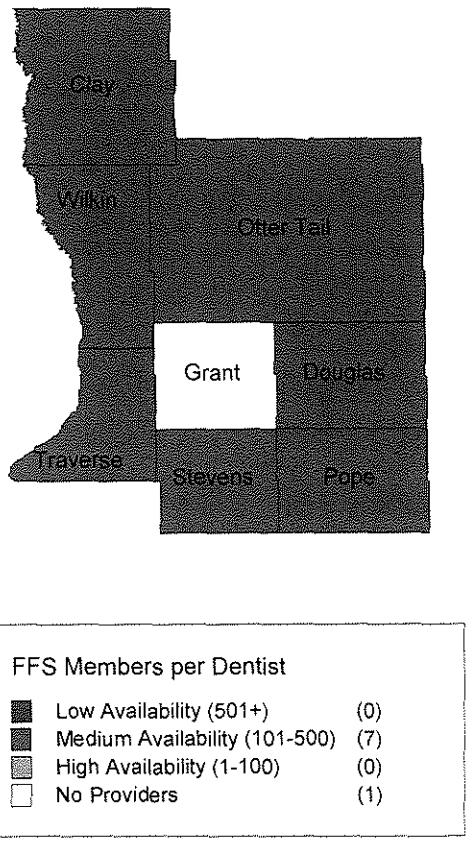


Exhibit III.D.3(i)
Dentist Utilization for Medicaid FFS Members in the West Central Region

	Level of Availability of Dentists	Visits per 1,000 FFS Enrollees
Statewide		**743**
Region		**773**
Clay	Medium	574
Douglas	Medium	820
Grant	No Provider	849
Otter Tail	Medium	888
Pope	Medium	788
Stevens	Medium	921
Traverse	Medium	1,279
Wilkin	Medium	720

Cardiologists, Neurologists and Orthopedic Surgeons

There is clearly no correlation between availability to specialist services in the county and utilization of these specialists when it pertains to cardiologists, neurologists and orthopedic surgeons in the West Central Region. Douglas, Otter Tail and Stevens are the only counties to have orthopedic surgeons, but only Douglas County has utilization near the statewide average (see Exhibit III.D.3(j) below). None of the counties in the region have a cardiologist or neurologist, yet Clay County enrollees have utilization for these services well above the statewide averages. Other counties in the region show utilization that is more expected (well below the statewide averages) when there are no specialists present for each of these services.

Exhibit III.D.3(j)
Utilization for Medicaid FFS Members in the West Central Region Among Other Specialists

	Provider Specialty Located in County?			Claims Per 1,000 FFS Enrollees		
	Cardiologist	Neurologist	Orthopedic Surgeon	Cardiologist	Neurologist	Orthopedic Surgeon
Statewide				**162**	**121**	**127**
Region				**121**	**105**	**109**
Clay	No	No	No	202	147	108
Douglas	No	No	Yes	56	95	133
Grant	No	No	No	26	48	95
Otter Tail	No	No	Yes	109	88	111
Pope	No	No	No	71	88	83
Stevens	No	No	Yes	90	42	73
Traverse	No	No	No	76	79	79
Wilkin	No	No	No	46	81	92

Central Region

OB/GYNs

In the Central Region, five of the 14 counties do not have an OB/GYN available to serve female FFS members (see Exhibit III.D.4(a) below). Mille Lacs County has low availability, while the remaining counties have medium availability (see Exhibit III.D.4(b) on the next page).

Although low availability or no availability appears to result in lower utilization in this region, the presence of OB/GYN providers does not necessarily mean higher utilization. The Central Region as a whole has 429 visits per 1,000 female FFS members over the two-year period studied. This is lower than the statewide average of 594 visits per 1,000. Benton (no availability), Stearns (medium availability) and Wright (medium availability) are the only counties in the region to exceed the statewide average utilization ratio (refer to Exhibit III.D.4(c) on the next page). Other than Benton County, the other counties with no OB/GYN availability have considerably lower utilization. But some of the medium availability counties (Crow Wing, Kanabec) also have low utilization similar to the counties with no providers present.

Exhibit III.D.4(a)
Density Map of OB/GYNs in the Central Region

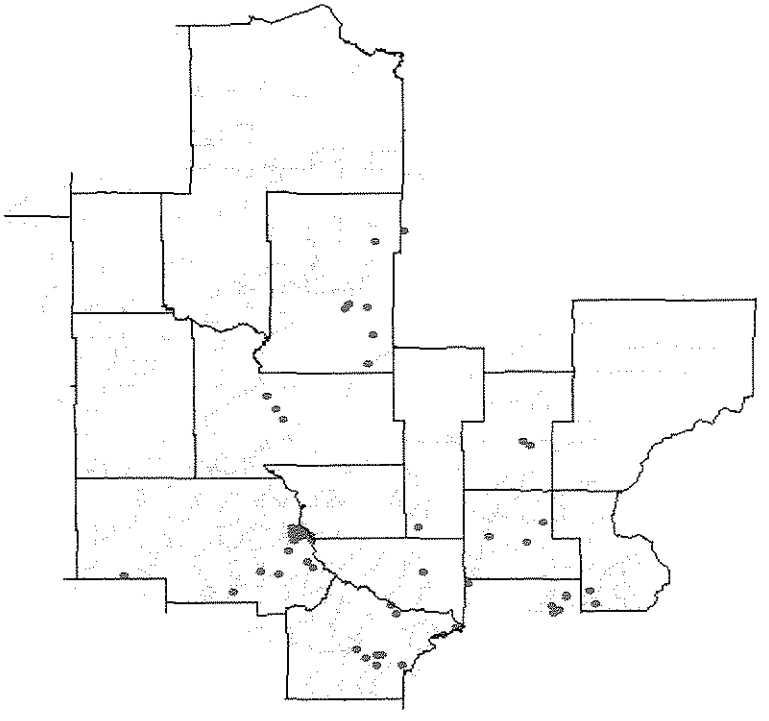


Exhibit III.D.4(b)
Comparison of Female FFS Members per OB/GYN in the Central Region

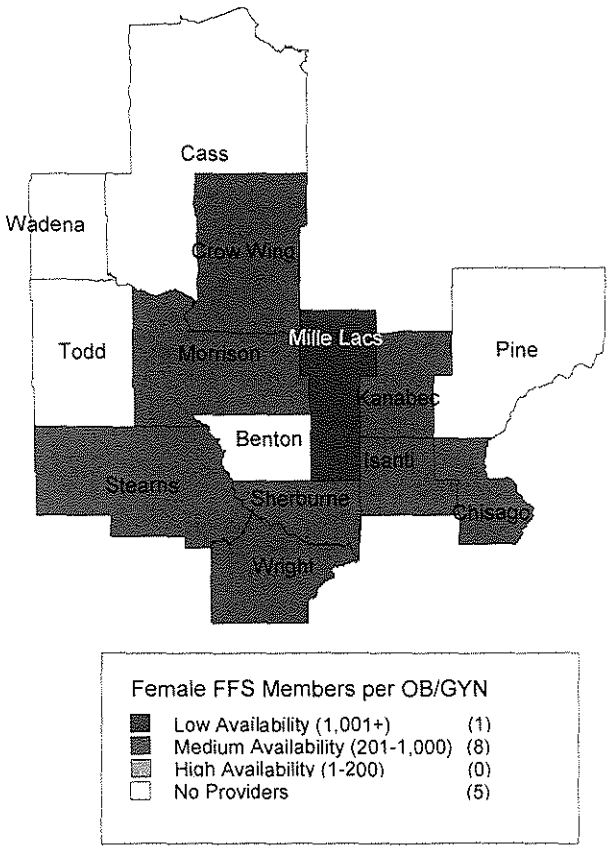


Exhibit III.D.4(c)
OB/GYN Utilization for Female Medicaid FFS Members in the Central Region

	Level of Availability of OB/GYNs	Visits per 1,000 Female FFS Enrollees
Statewide		**594**
Region		**429**
Benton	No Provider	642
Cass	No Provider	392
Chisago	Medium	381
Crow Wing	Medium	264
Isanti	Medium	319
Kanabec	Medium	271
Mille Lacs	Low	252
Morrison	Medium	367
Pine	No Provider	260
Sherburne	Medium	555
Stearns	Medium	589
Todd	No Provider	163
Wadena	No Provider	111
Wright	Medium	604

Psychiatrists

Seven of the 14 counties in the Central Region do not have a psychiatrist available three counties (Wadena, Mille Lacs and Chisago) only have one (see Exhibit III.D.4(d) below). Isanti, Crow Wing and Stearns have medium availability (see Exhibit III.D.4(e) on the next page) as does Wadena which, despite having only one psychiatrist, has low FFS enrollment.

As a whole, the Central Region has lower utilization of psychiatrist services across the board. The two notable exceptions are Benton (449 visits per 1,000 FFS members) and Chisago (476 visits per 1,000). Each of these counties has utilization slightly above the statewide average (433 visits per 1,000) despite the fact that Benton County has no providers and Chisago only has one (refer to Exhibit III.D.4(f) on the next page). This means that the FFS members are accessing psychiatrist services in counties outside of their home county.

Exhibit III.D.4(d)
Density Map of Psychiatrists in the Central Region

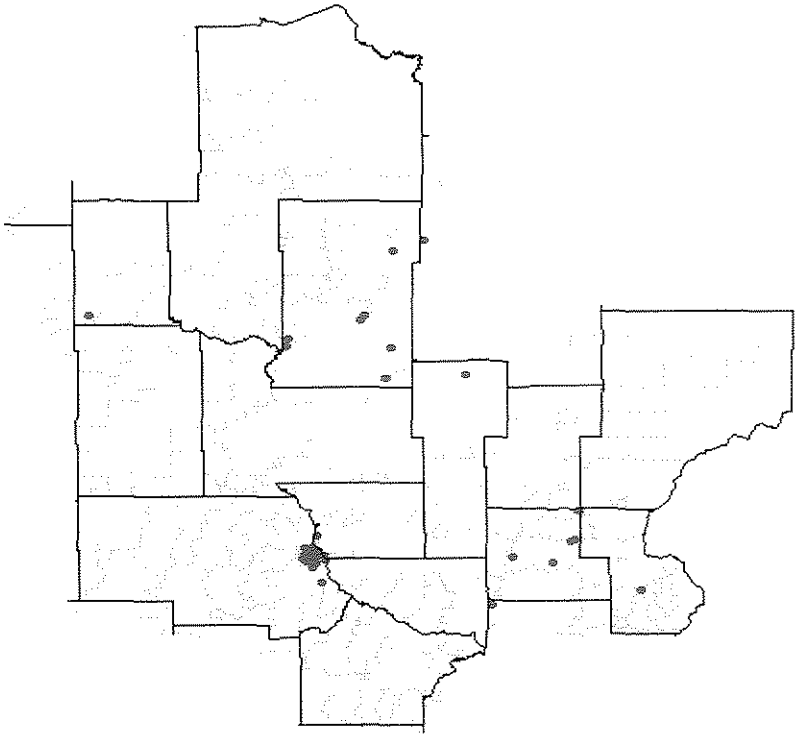


Exhibit III.D.4(e)
Comparison of FFS Members per Psychiatrist in the Central Region

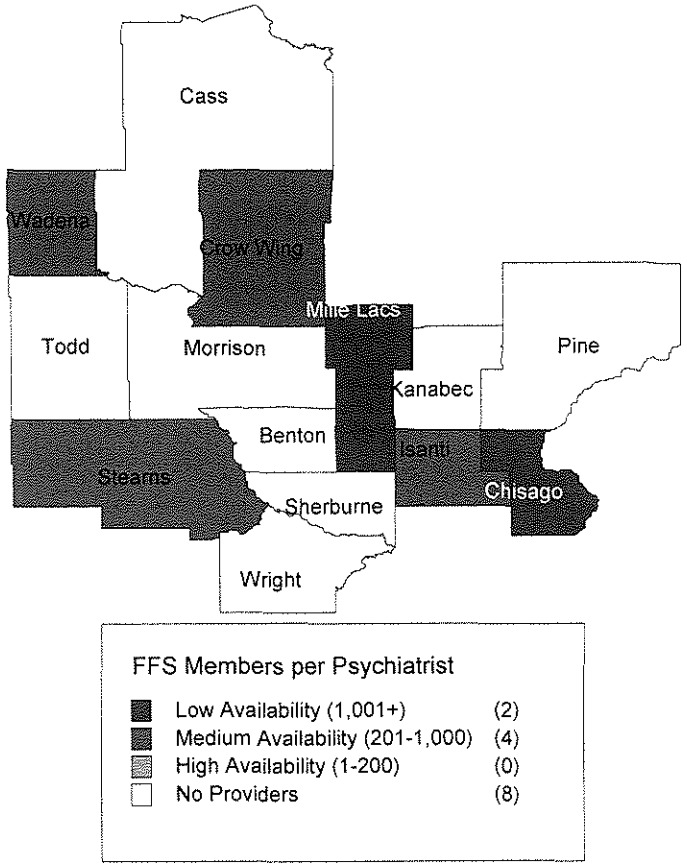


Exhibit III.D.4(f)
Psychiatrist Utilization for Medicaid FFS Members in the Central Region

	Level of Availability of Psychiatrists	Visits per 1,000 FFS Enrollees
Statewide		**433**
Region		**322**
Benton	No Provider	449
Cass	No Provider	242
Chisago	Low	476
Crow Wing	Medium	364
Isanti	Medium	335
Kanabec	No Provider	215
Mille Lacs	Low	344
Morrison	No Provider	229
Pine	No Provider	208
Sherburne	No Provider	274
Stearns	Medium	396
Todd	No Provider	157
Wadena	Medium	372
Wright	No Provider	272

Dentists

There are dentists available to FFS enrollees in all counties in the Central Region (refer to Exhibit III.D.4(g) below), but Chisago and Pine Counties are considered low availability while the other counties are considered medium availability levels (refer to Exhibit III.D.4(h) on the next page).

The two low availability counties do have lower utilization than most of their peers in the Central Region, but this utilization is not much different than the statewide average. Chisago County has 723 visits per 1,000 FFS members in the two-year study period, Pine County has 754 visits per 1,000, and the statewide average is 743 visits per 1,000. Refer to Exhibit III.D.4(i) on the next page for more details. Five of the counties in this region actually have significantly higher utilization than the statewide average.

Exhibit III.D.4(g)
Density Map of Dentists in the Central Region

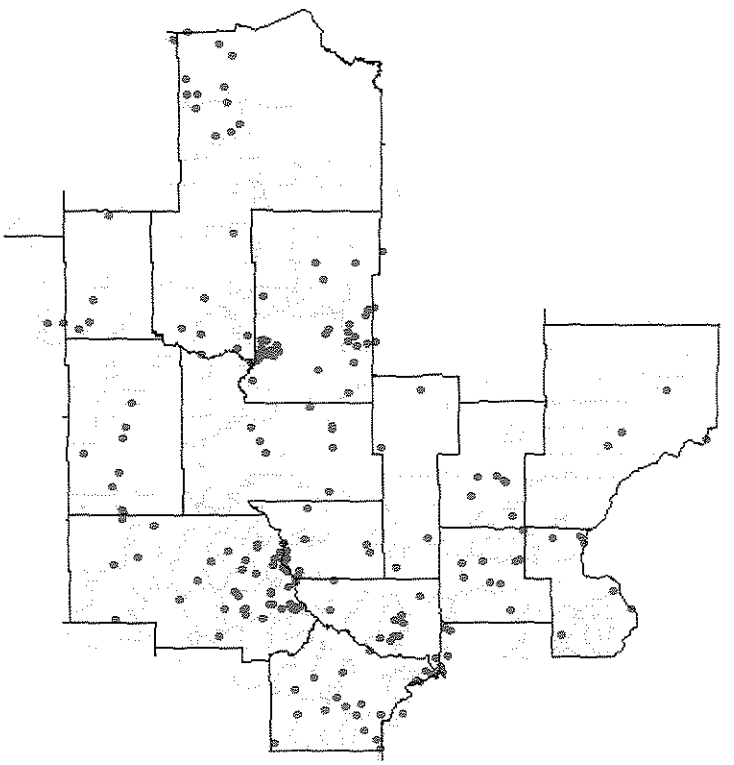


Exhibit III.D.4(h)
Comparison of FFS Members per Dentist in the Central Region

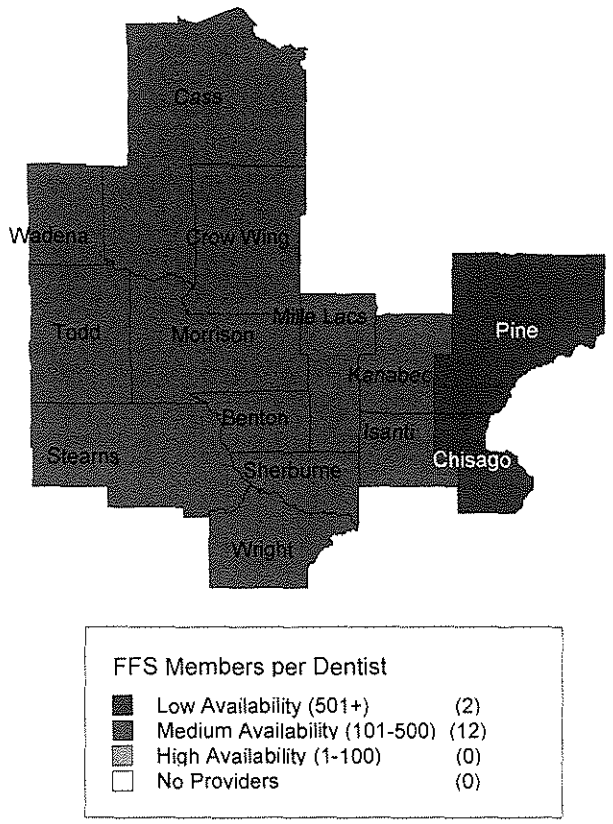


Exhibit III.D.4(i)
Dentist Utilization for Medicaid FFS Members in the Central Region

	Level of Availability of Dentists	Visits per 1,000 FFS Enrollees
Statewide		**743**
Region		**879**
Benton	Medium	714
Cass	Medium	1,094
Chisago	Low	723
Crow Wing	Medium	1,426
Isanti	Medium	712
Kanabec	Medium	705
Mille Lacs	Medium	654
Morrison	Medium	1,113
Pine	Low	754
Sherburne	Medium	659
Stearns	Medium	688
Todd	Medium	1,246
Wadena	Medium	1,507
Wright	Medium	661

Cardiologists, Neurologists and Orthopedic Surgeons

The Central Region has more neurologists and orthopedic surgeons than other regions, and it appears that the utilization reflects this availability. Four of the counties with a neurologist have utilization that is greater than the region average and statewide average while the other two counties with a neurologist are below the statewide average (see Exhibit III.D.4(j) below). The presence of an orthopedic surgeon is less telling. Among the eight counties with an orthopedic surgeon, only three have utilization greater than the statewide average while five are lower. Yet other counties without an orthopedic surgeon (Benton, Cass, Todd) have utilization that is higher than the statewide average.

On the whole, the Central Region has utilization for cardiologists that is below the statewide average. The presence of a cardiologist in the county (Stearns, Wright) is not indicative of higher utilization.

Exhibit III.D.4(j)
Utilization for Medicaid FFS Members in the Central Region Among Other Specialists

	Provider Specialty Located in County?			Claims Per 1,000 FFS Enrollees		
	Cardiologist	Neurologist	Orthopedic Surgeon	Cardiologist	Neurologist	Orthopedic Surgeon
Statewide				**162**	**121**	**127**
Region				**96**	**122**	**150**
Benton	No	No	No	113	130	211
Cass	No	No	No	122	102	142
Chisago	No	Yes	Yes	108	173	89
Crow Wing	No	Yes	Yes	85	82	193
Isanti	No	Yes	Yes	83	146	91
Kanabec	No	No	Yes	74	114	113
Mille Lacs	No	Yes	No	105	128	123
Morrison	No	No	Yes	56	100	205
Pine	No	No	No	135	122	102
Sherburne	No	No	Yes	109	135	124
Stearns	Yes	Yes	Yes	85	149	189
Todd	No	No	No	98	91	141
Wadena	No	No	No	111	96	128
Wright	Yes	Yes	Yes	92	109	122

Metropolitan Region

OB/GYNs

The Metro Region has adequate accessibility to OB/GYNs for the female FFS population (see Exhibit III.D.5(a) below). Carver and Washington Counties have high availability while the remaining counties have medium availability (see Exhibit III.D.5(b) on the next page).

The region as whole has visits per 1,000 female FFS members that are higher than the statewide average (628 versus 594). The variance around the region's average is not too wide at the county level, with the exception of Washington County which—at 486 visits per 1,000—is much lower than the other counties. Refer to Exhibit III.D.5(c) on the next page for more details.

Exhibit III.D.5(a)
Density Map of OB/GYNs in the Metro Region

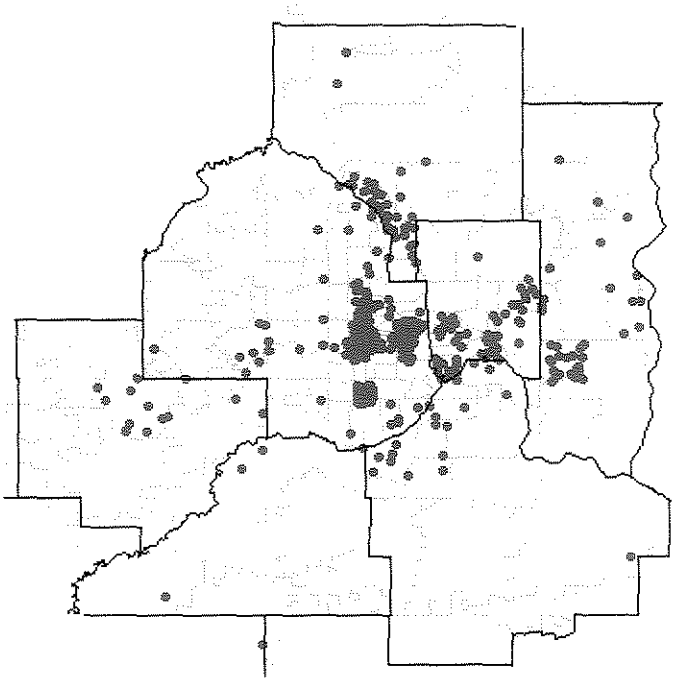
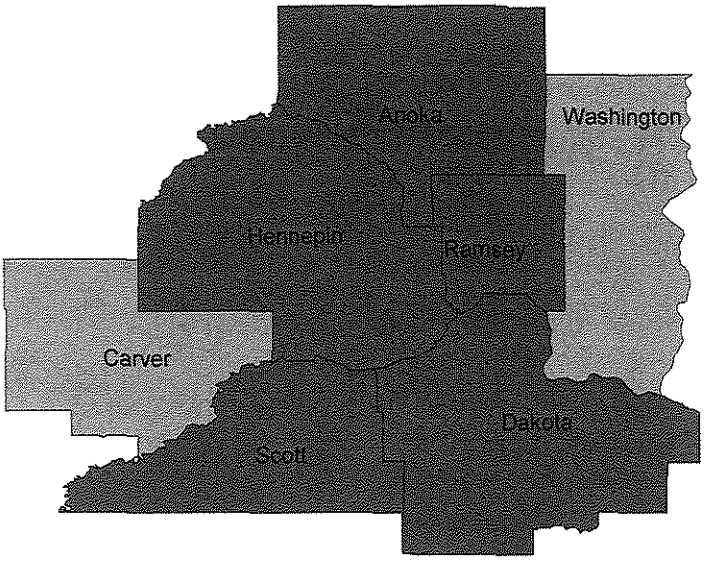


Exhibit III.D.5(b)
Comparison of Female FFS Members per OB/GYN in the Metro Region



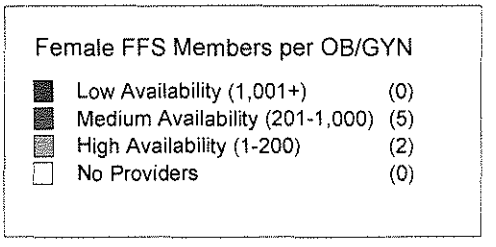


Exhibit III.D.5(c)
OB/GYN Utilization for Female Medicaid FFS Members in the Metro Region

	Level of Availability of OB/GYNs	Visits per 1,000 Female FFS Enrollees
Statewide		**594**
Region		**628**
Anoka	Medium	710
Carver	High	548
Dakota	Medium	572
Hennepin	Medium	681
Ramsey	Medium	550
Scott	Medium	601
Washington	High	486

Psychiatrists

Although there are psychiatrists available to serve FFS members in each of the seven counties in the Metro Region (see Exhibit III.D.5(d) below), availability is considered low in Carver, Dakota and Scott counties. The other four counties have medium availability (see Exhibit III.D.5(e) on the next page).

As a whole, the Metro Region has higher utilization of psychiatrist services (467 visits per 1,000 FFS members) than the statewide average (433 visits per 1,000). But Carver County (279 visits per 1,000) and Scott County (362 visits per 1,000) have lower utilization than their peers in the region. Both counties are low availability counties, and this may be a factor of the lower utilization (refer to Exhibit III.D.5(f) on the next page).

Exhibit III.D.5(d)
Density Map of Psychiatrists in the Metro Region

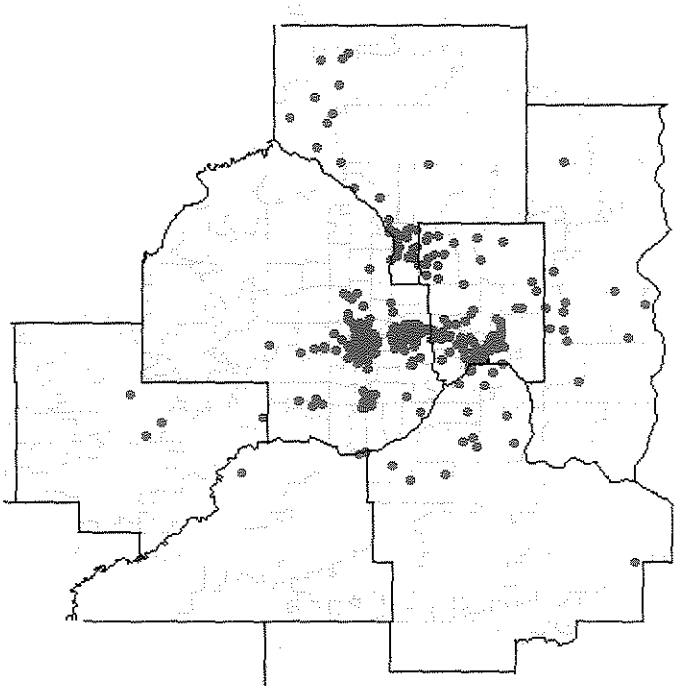


Exhibit III.D.5(e)
Comparison of FFS Members per Psychiatrist in the Metro Region

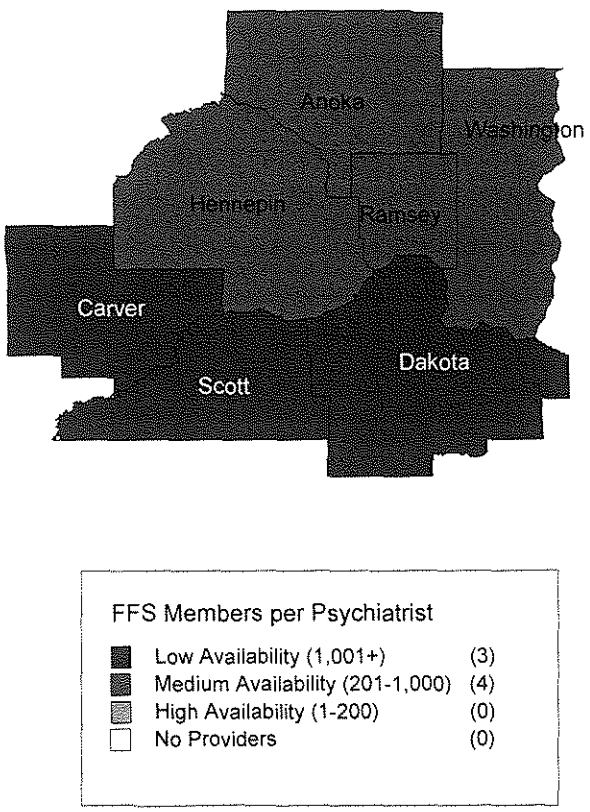


Exhibit III.D.5(f)
Psychiatrist Utilization for Medicaid FFS Members in the Metro Region

	Level of Availability of Psychiatrists	Visits per 1,000 FFS Enrollees
Statewide		**433**
Region		**467**
Anoka	Medium	547
Carver	Low	279
Dakota	Low	461
Hennepin	Medium	440
Ramsey	Medium	513
Scott	Low	362
Washington	Medium	479

Dentists

There are dentists available to FFS enrollees in all counties in the Metro Region (refer to Exhibit III.D.5(g) below), and all of the counties are considered medium availability levels (refer to Exhibit III.D.5(h) on the next page).

Dental utilization, however, is lower in the Metro Region than the statewide average when measured on a per 1,000 FFS member basis. The region average is 662 visits per 1,000 while the statewide average is 743 visits per 1,000. Despite relatively good availability to dentists, Hennepin (616 per 1,000) and Washington (630 per 1,000) Counties in particular have utilization much lower than the statewide average. Refer to Exhibit III.D.5(i) on the next page for more details.

Exhibit III.D.5(g)
Density Map of Dentists in the Metro Region

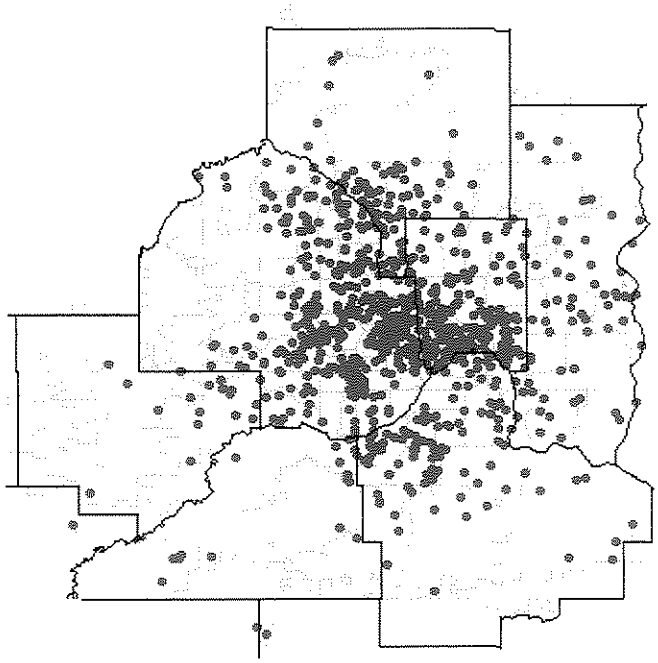


Exhibit III.D.5(h)
Comparison of FFS Members per Dentist in the Metro Region

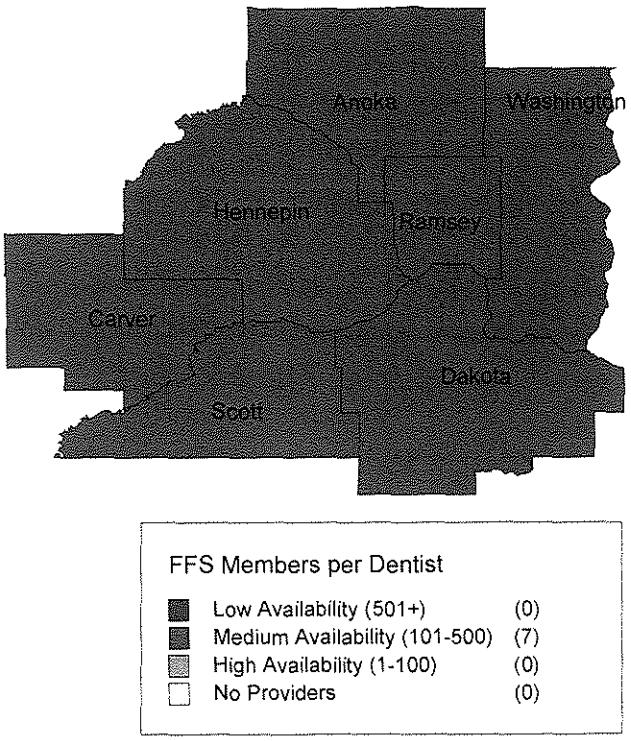


Exhibit III.D.5(i)
Dentist Utilization for Medicaid FFS Members in the Metro Region

	Level of Availability of Dentists	Visits per 1,000 FFS Enrollees
Statewide		**743**
Region		**662**
Anoka	Medium	743
Carver	Medium	716
Dakota	Medium	682
Hennepin	Medium	616
Ramsey	Medium	709
Scott	Medium	755
Washington	Medium	630

Cardiologists, Neurologists and Orthopedic Surgeons

It is interesting to note that availability of specialist practitioners, or the lack thereof, is not correlating closely to increased utilization. The Metro Region, for example, has greater availability of cardiologists, neurologists and orthopedic surgeons than any other region in the state (outside of Olmstead County). However, this is not necessarily translating to increased availability at the county level. For cardiology, the Metro Region accounts for two-thirds of all of the claims in the FFS program; for neurology and orthopedic surgery, roughly half. Hennepin and Ramsey Counties do experience higher cardiology utilization than the statewide average. For neurology, Anoka and Scott Counties are considerably higher, though Scott County does not have a neurologist in the county. For orthopedic surgery, Anoka County has a significantly higher utilization than the statewide average yet every county in the region has orthopedic surgeons present.

The analysis completed in this study counts member's utilization of services based on where the member lives, not where the service was delivered. For these services in particular, it appears that since other regions are experiencing utilization similar to the Metro Region's FFS members, the members from other regions may be traveling to the Metro Region to receive services since the providers are located here.

Exhibit III.D.5(j)
Utilization for Medicaid FFS Members in the Metro Region Among Other Specialists

	Provider Specialty Located in County?			Claims Per 1,000 FFS Enrollees		
	Cardiologist	Neurologist	Orthopedic Surgeon	Cardiologist	Neurologist	Orthopedic Surgeon
Statewide				**162**	**121**	**127**
Region				**207**	**128**	**122**
Anoka	Yes	Yes	Yes	171	162	170
Carver	No	No	Yes	124	105	115
Dakota	Yes	Yes	Yes	139	124	125
Hennepin	Yes	Yes	Yes	246	136	116
Ramsey	Yes	Yes	Yes	195	99	113
Scott	No	No	Yes	114	157	134
Washington	Yes	No	Yes	146	119	120

Southwest Region

OB/GYNs

Only three counties in the Southwest Region (Kandiyohi, Lyon and Nobles) have OB/GYN providers available to serve the female FFS population (see Exhibit III.D.6(a) below), but all three are considered medium availability counties (see Exhibit III.D.6(b) on the next page).

The region as whole has visits per 1,000 female FFS members that are lower than the statewide average (427 versus 594). Only two counties have utilization greater than the statewide average—Murray (833 visits per 1,000) and Nobles (1,138 visits per 1,000). Notably, Murray County does not have an OB/GYN provider while Nobles has several. Many of the counties in this region have very low OB/GYN utilization. Refer to Exhibit III.D.6(c) on the next page for more details.

Exhibit III.D.6(a)
Density Map of OB/GYNs in the Southwest Region

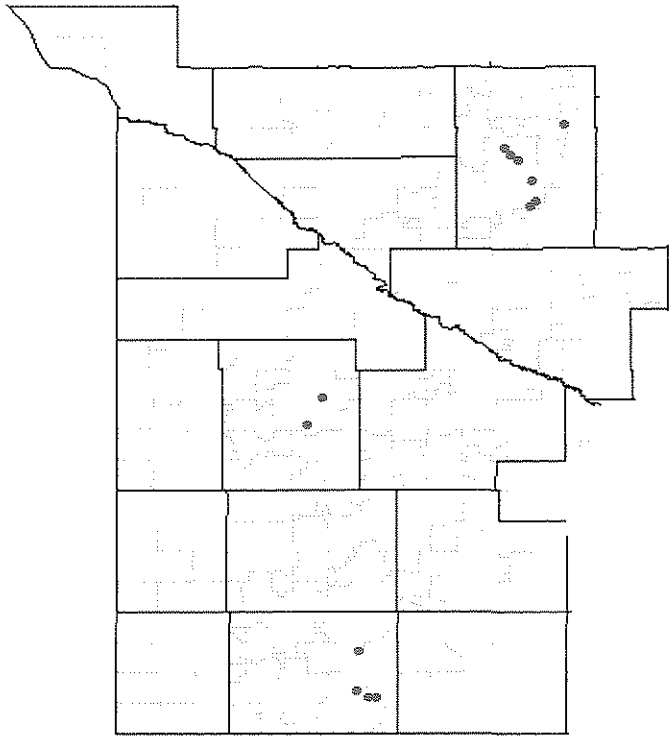


Exhibit III.D.6(b)
Comparison of Female FFS Members per OB/GYN in the Southwest Region

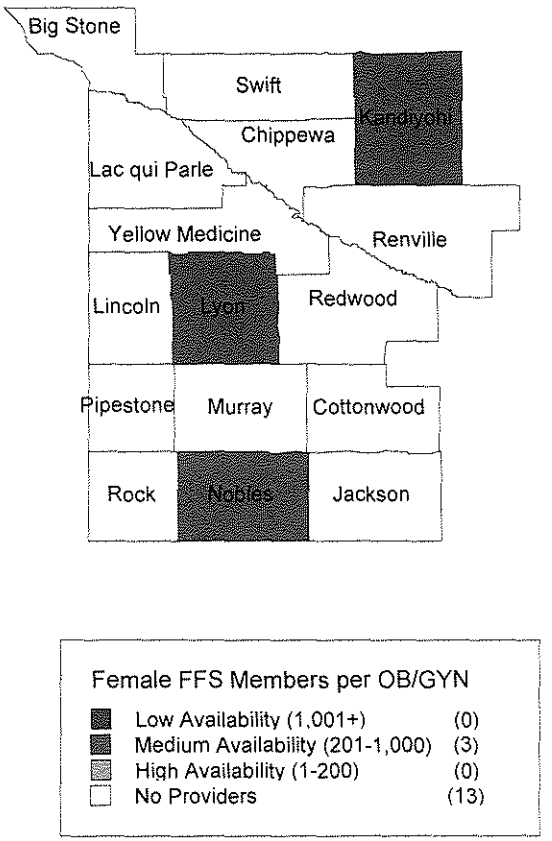


Exhibit III.D.6(c)
OB/GYN Utilization for Female Medicaid FFS Members in the Southwest Region

	Level of Availability of OB/GYNs	Visits per 1,000 Female FFS Enrollees
Statewide		**594**
Region		**427**
Big Stone	No Provider	129
Chippewa	No Provider	217
Cottonwood	No Provider	207
Jackson	No Provider	468
Kandiyohi	No Provider	406
Lac Qui Parle	No Provider	144
Lincoln	No Provider	407
Lyon	Medium	472
Murray	No Provider	833
Nobles	Medium	1,138
Pipestone	No Provider	355
Redwood	No Provider	176
Renville	No Provider	256
Rock	No Provider	151
Swift	No Provider	261
Yellow Medicine	No Provider	333

Psychiatrists

Only four of the 16 counties in the Southwest Region have psychiatrists available to serve FFS members (see Exhibit III.D.6(d) below). Among these, Lyon and Pipestone Counties are considered low availability while Kandiyohi and Rock Counties are considered medium availability (see Exhibit III.D.6(e) on the next page).

In almost all cases, the Southwest Region counties have psychiatrist utilization much below the statewide average of 433 visits per 1,000. The notable exception is Lac Qui Parle County (423 visits per 1,000). It is interesting to note that the two medium availability counties—Kandiyohi and Rock Counties—while having utilization greater than their region's average still have psychiatrist utilization below the statewide average. Refer to Exhibit III.D.6(f) on the next page for more details.

Exhibit III.D.6(d)
Density Map of Psychiatrists in the Southwest Region

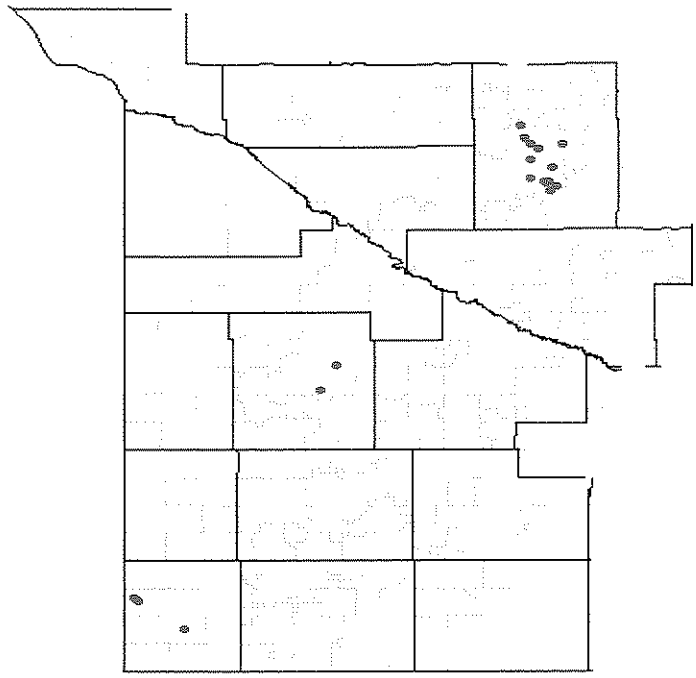


Exhibit III.D.6(e)
Comparison of FFS Members per Psychiatrist in the Southwest Region

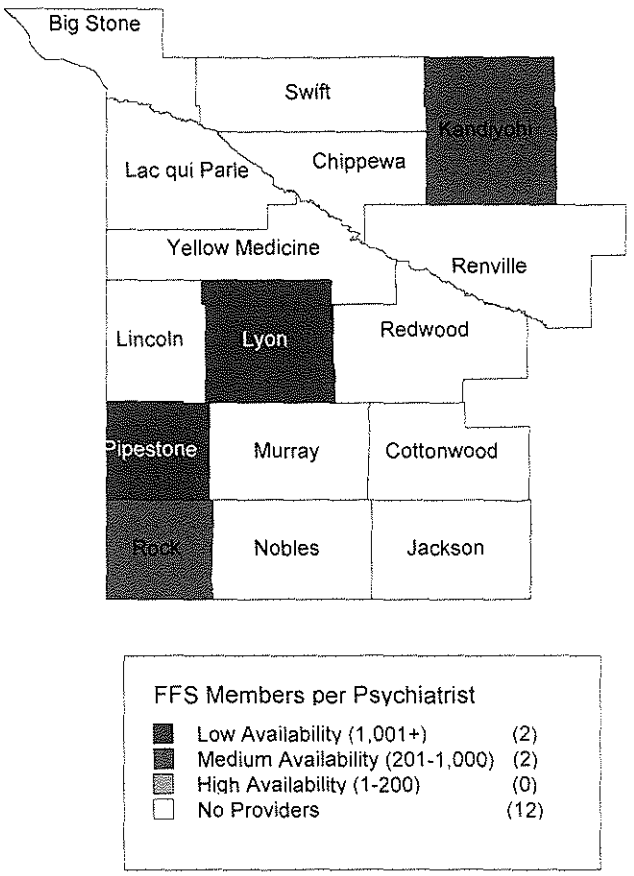


Exhibit III.D.6(f)
Psychiatrist Utilization for Medicaid FFS Members in the Southwest Region

	Level of Availability to Psychiatrists	Visits per 1,000 FFS Enrollees
Statewide		**433**
Region		**293**
Big Stone	No Provider	381
Chippewa	No Provider	189
Cottonwood	No Provider	215
Jackson	No Provider	209
Kandiyohi	Medium	364
Lac Qui Parle	No Provider	423
Lincoln	No Provider	181
Lyon	Low	295
Murray	No Provider	319
Nobles	No Provider	212
Pipestone	Low	329
Redwood	No Provider	239
Renville	No Provider	384
Rock	Medium	327
Swift	No Provider	386
Yellow Medicine	No Provider	159

Dentists

Though few in many counties, there are dentists available to FFS members in every county in the Southwest Region (see Exhibit III.D.6(g) below). Because of the low enrollment in this region, most counties are considered medium availability counties for dental services, the exceptions being Pipestone and Rock Counties which are low availability (see Exhibit III.D.6(h) on the next page).

Dental utilization, measured on a per 1,000 FFS member basis, is actually higher in the Southwest Region (766) than the statewide average (743). The two counties with low availability do have the lowest utilization as well. Among the medium availability counties, utilization varies widely, from Yellow Medicine County's 523 visits per 1,000 to Murray County's 1,203 visits per 1,000. More details are shown in Exhibit III.D.6(i) on the next page.

Exhibit III.D.6(g)
Density Map of Dentists in the Southwest Region

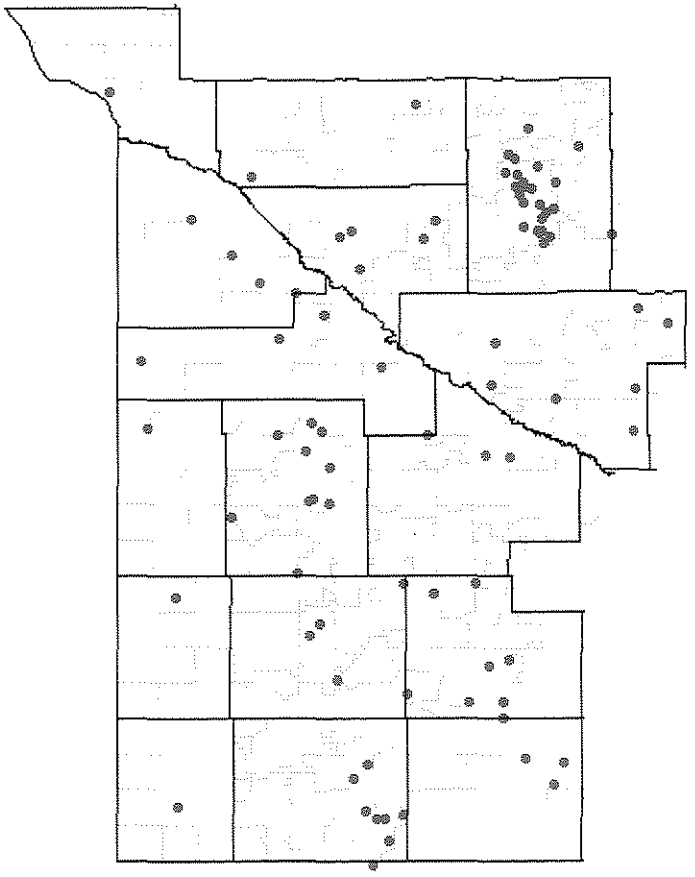


Exhibit III.D.6(h)
Comparison of FFS Members per Dentist in the Southwest Region

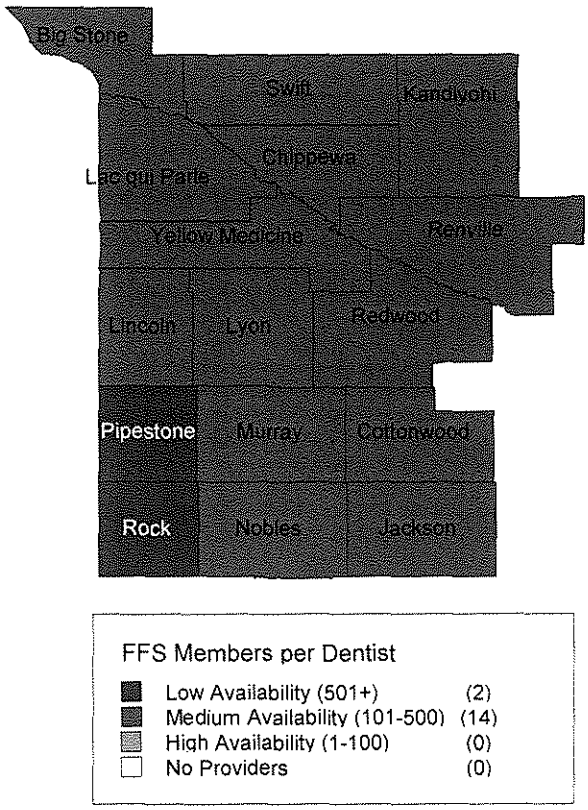


Exhibit III.D.6(i)
Dentist Utilization for Medicaid FFS Members in the Southwest Region

	Level of Availability of Dentists	Visits per 1,000 FFS Enrollees
Statewide		**743**
Region		**766**
Big Stone	Medium	921
Chippewa	Medium	628
Cottonwood	Medium	891
Jackson	Medium	615
Kandiyohi	Medium	1,170
Lac Qui Parle	Medium	613
Lincoln	Medium	533
Lyon	Medium	759
Murray	Medium	1,203
Nobles	Medium	595
Pipestone	Low	435
Redwood	Medium	633
Renville	Medium	656
Rock	Low	457
Swift	Medium	650
Yellow Medicine	Medium	523

Cardiologists, Neurologists and Orthopedic Surgeons

There is only one cardiologist, two neurologists and six orthopedic surgeons available to FFS members in the entire Southwest Region. These are located in Kandiyohi and Murray Counties. Although Murray County has higher utilization than other counties in the region and the statewide average for cardiologist and orthopedic surgeon services, Kandiyohi County does not have higher utilization despite the presence of these specialties in the county.

Overall, utilization for these specialist services is much lower than the statewide thresholds, although actual utilization at the county level varies significantly. See Exhibit III.D.6(j) below for more details.

Exhibit III.D.6(j)
Utilization for Medicaid FFS Members in the Southwest Region Among Other Specialists

	Provider Specialty Located in County?			Claims Per 1,000 FFS Enrollees		
	Cardiologist	Neurologist	Orthopedic Surgeon	Cardiologist	Neurologist	Orthopedic Surgeon
Statewide				**162**	**121**	**127**
Region				**88**	**82**	**85**
Big Stone	No	No	No	79	50	96
Chippewa	No	No	No	86	89	51
Cottonwood	No	No	No	64	167	107
Jackson	No	No	No	68	42	76
Kandiyohi	No	Yes	Yes	76	87	83
Lac Qui Parle	No	No	No	118	45	121
Lincoln	No	No	No	65	99	52
Lyon	No	No	No	92	60	81
Murray	Yes	No	Yes	203	109	141
Nobles	No	No	No	64	72	87
Pipestone	No	No	No	86	51	97
Redwood	No	No	No	135	67	54
Renville	No	No	No	105	115	116
Rock	No	No	No	45	100	75
Swift	No	No	No	113	70	76
Yellow Medicine	No	No	No	70	75	89

South Central Region

OB/GYNs

All counties but Faribault County have at least one OB/GYN provider available to serve the female FFS population (see Exhibit III.D.7(a) below), but Nicollet and Le Sueur Counties considered low availability counties. The remaining counties are considered medium availability (see Exhibit III.D.7(b) on the next page).

The region average utilization of OB/GYN visits per 1,000 female FFS members (561) is near the statewide average (594), but there is wide variation at the county level. It is interesting to note that the counties with the lowest availability to OB/GYN providers in their counties are among the higher utilization counties in the region. Refer to Exhibit III.D.7(c) on the next page for more details.

Exhibit III.D.7(a)
Density Map of OB/GYNs in the South Central Region

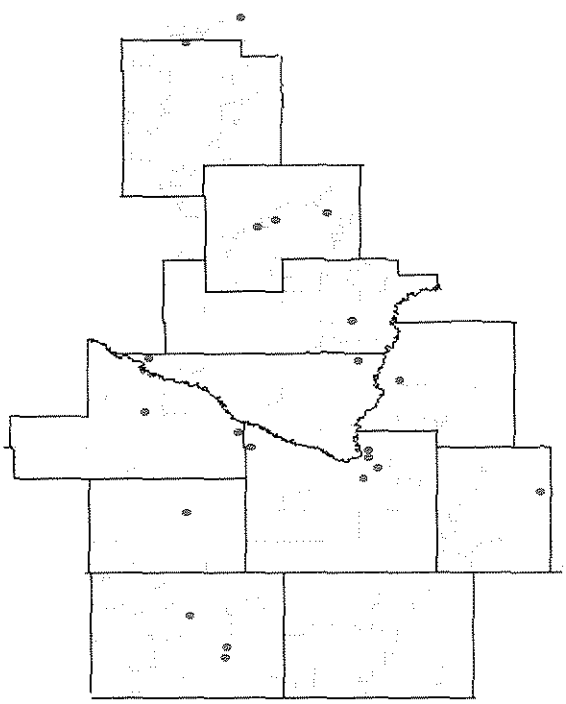


Exhibit III.D.7(b)
Comparison of Female FFS Members per OB/GYN in the South Central Region

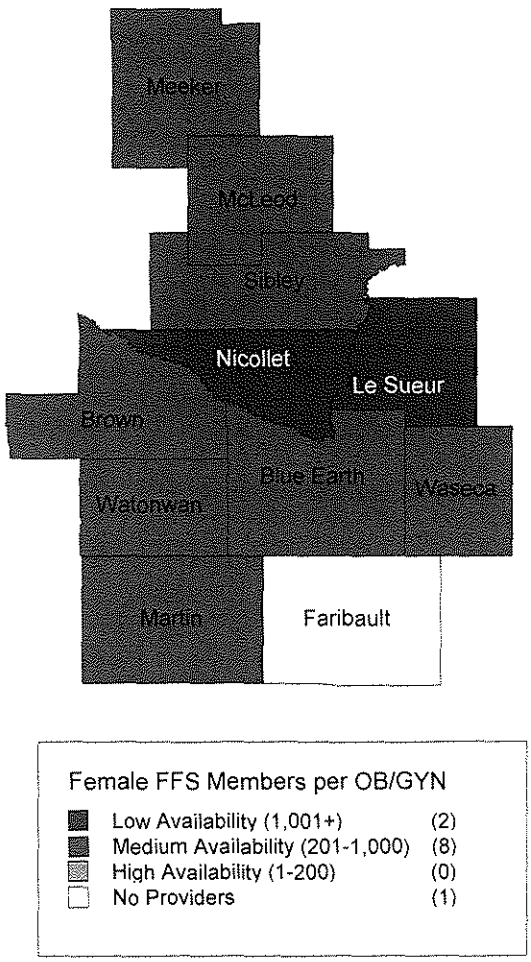


Exhibit III.D.7(c)
OB/GYN Utilization for Female Medicaid FFS Members in the South Central Region

	Level of Availability of OB/GYNs	Visits per 1,000 Female FFS Enrollees
Statewide		**594**
Region		**561**
Blue Earth	Medium	830
Brown	Medium	370
Faribault	No Provider	539
Le Sueur	Low	648
McLeod	Medium	366
Martin	Medium	531
Meeker	Medium	250
Nicollet	Low	623
Sibley	Medium	373
Waseca	Medium	571
Watonwan	Medium	483

Psychiatrists

Among the South Central Region's 11 counties, five have psychiatrists available to serve FFS members (see Exhibit III.D.7(d) below). Among these, Le Sueur County is considered low availability while the other five counties are considered medium availability (see Exhibit III.D.7(e) on the next page).

The counties with no psychiatrist available typically have lower utilization of this service than the other counties in the region, but Waseca County is the exception. With utilization of 468 visits per 1,000 FFS members, this county exceeds the region's utilization average (372) as well as the statewide average (433). Blue Earth County (463 visits per 1,000) and Nicollet County (472 visits per 1,000) also exceed the statewide average, while the remaining counties have utilization considerably lower than other counties in the state. Refer to Exhibit III.D.7(f) on the next page for more details.

Exhibit III.D.7(d)
Density Map of Psychiatrists in the South Central Region

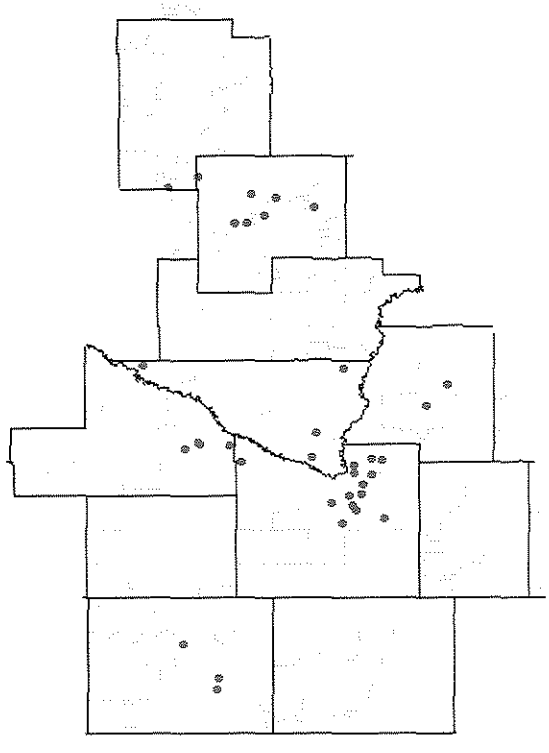


Exhibit III.D.7(e)
Comparison of FFS Members per Psychiatrist in the South Central Region

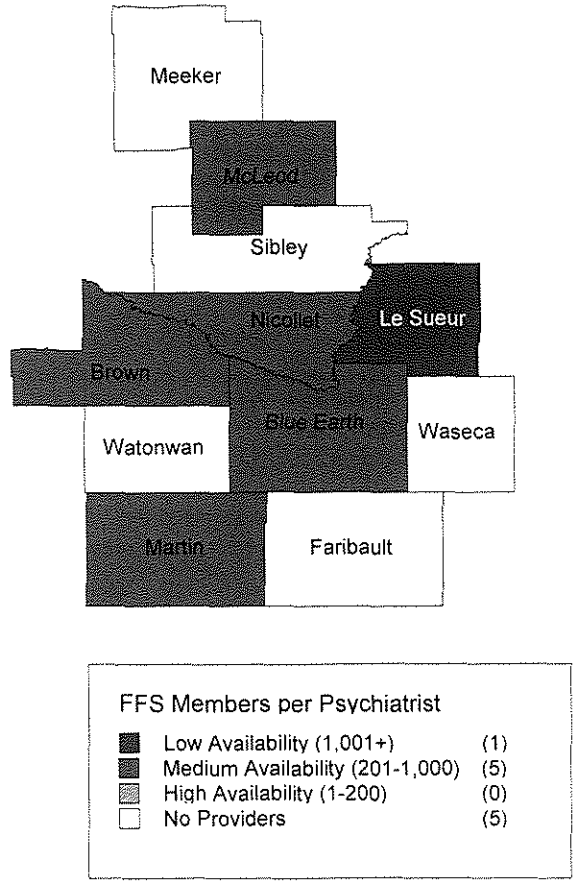


Exhibit III.D.7(f)
Psychiatrist Utilization for Medicaid FFS Members in the South Central Region

	Level of Availability of Psychiatrists	Visits per 1,000 FFS Enrollees
Statewide		**433**
Region		**372**
Blue Earth	Medium	463
Brown	Medium	349
Faribault	No Provider	306
Le Sueur	Low	335
McLeod	Medium	381
Martin	Medium	299
Meeker	No Provider	298
Nicollet	Medium	472
Sibley	No Provider	163
Waseca	No Provider	468
Watonwan	No Provider	201

Dentists

All of the counties in the South Central Region have a dentist available to serve FFS members (the one dentist in Watonwan County is in a zip code that straddles Watonwan and Blue Earth Counties), as seen in Exhibit III.D.7(g) below. Other than Watonwan County, each county is considered medium availability for dental services (see Exhibit III.D.7(h) on the next page).

With respect to dental utilization, the South Central Region as a whole exhibits utilization rates near the statewide average (767 visits per 1,000 versus the statewide average of 743 visits per 1,000). Additionally, most counties have utilization rates that cluster around this average. The exceptions are Sibley County (447 per 1,000) and Watonwan County (503 per 1,000). More details are shown in Exhibit III.D.7(i) on the next page.

Exhibit III.D.7(g)
Density Map of Dentists in the South Central Region

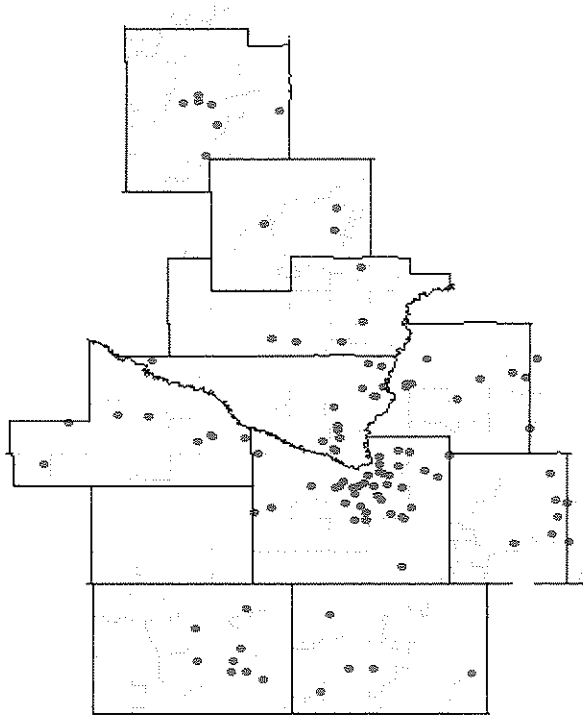


Exhibit III.D.7(h)
Comparison of FFS Members per Dentist in the South Central Region

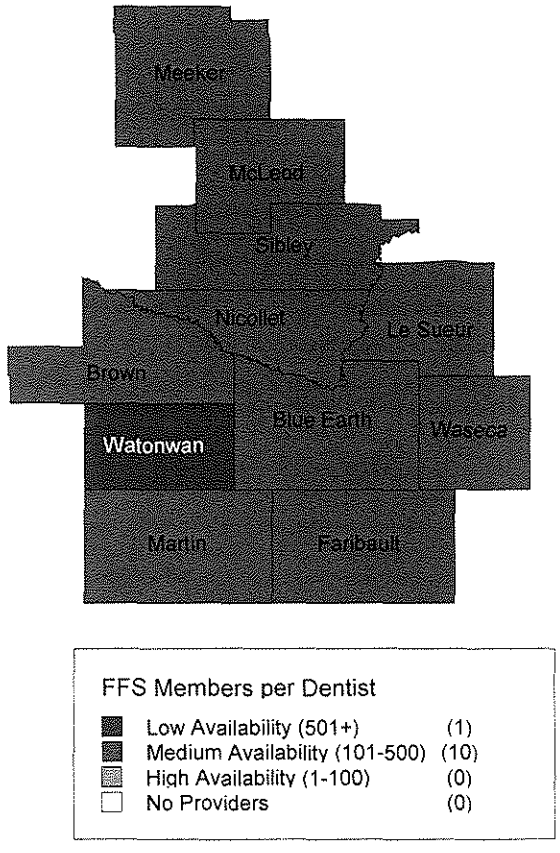


Exhibit III.D.7(i)
Dentist Utilization for Medicaid FFS Members in the South Central Region

	Level of Availability to Dentists	Visits per 1,000 FFS Enrollees
Statewide		**743**
Region		**767**
Blue Earth	Medium	941
Brown	Medium	754
Faribault	Medium	711
Le Sueur	Medium	787
McLeod	Medium	760
Martin	Medium	728
Meeker	Medium	746
Nicollet	Medium	796
Sibley	Medium	447
Waseca	Medium	684
Watonwan	Low	503

Cardiologists, Neurologists and Orthopedic Surgeons

There are orthopedic surgeons available in six of the 11 counties in the South Central Region, but there are neurologists in only three counties and cardiologists in only one county. Despite the number of orthopedic surgeons in the region, utilization rates are not necessarily higher in the counties where one is present (see Exhibit III.D.7(j) below). For example, Brown (71 per 1,000), Meeker (104 per 1,000) and Sibley (98 per 1,000) all have utilization rates below the statewide average (127 per 1,000) whereas some counties with no surgeon have utilization rates that exceed the statewide average.

For neurology, only Blue Earth (129 per 1,000) and Le Sueur (150 per 1,000) have utilization rates above the statewide average. Cardiology utilization rates are significantly lower than the statewide average across-the-board in the South Central Region.

Exhibit III.D.7(j)
Utilization for Medicaid FFS Members in the South Central Region Among Other Specialists

	Provider Specialty Located in County?			Claims Per 1,000 FFS Enrollees		
	Cardiologist	Neurologist	Orthopedic Surgeon	Cardiologist	Neurologist	Orthopedic Surgeon
Statewide				**162**	**121**	**127**
Region				**84**	**105**	**149**
Blue Earth	Yes	Yes	Yes	91	129	223
Brown	No	No	Yes	72	92	71
Faribault	No	Yes	Yes	80	109	194
Le Sueur	No	No	No	98	150	143
McLeod	No	Yes	No	68	84	61
Martin	No	No	Yes	97	97	210
Meeker	No	No	Yes	66	91	104
Nicollet	No	No	No	122	116	165
Sibley	No	No	Yes	74	63	98
Waseca	No	No	No	79	87	143
Watonwan	No	No	No	29	68	64

Southeast Region

OB/GYNs

There is a wide variety of availability of OB/GYNs in the Southeast Region, ranging from a higher density of providers in Rochester to no availability in Dodge, Fillmore, Houston and Wabasha Counties (see Exhibit III.D.8(a) below). Mower County is considered low availability, Olmstead County is considered high availability, and the western counties as well as Winona County are considered medium availability (see Exhibit III.D.8(b) on the next page).

OB/GYN utilization, measured on a per 1,000 female FFS member basis, is higher in the Southeast Region (723) than the statewide average (594). The four counties with no OB/GYN providers do have lower utilization than the others, while most of the remaining counties have utilization near the region's average. Refer to Exhibit III.D.8(c) on the next page for more details.

Exhibit III.D.8(a)
Density Map of OB/GYNs in the Southeast Region

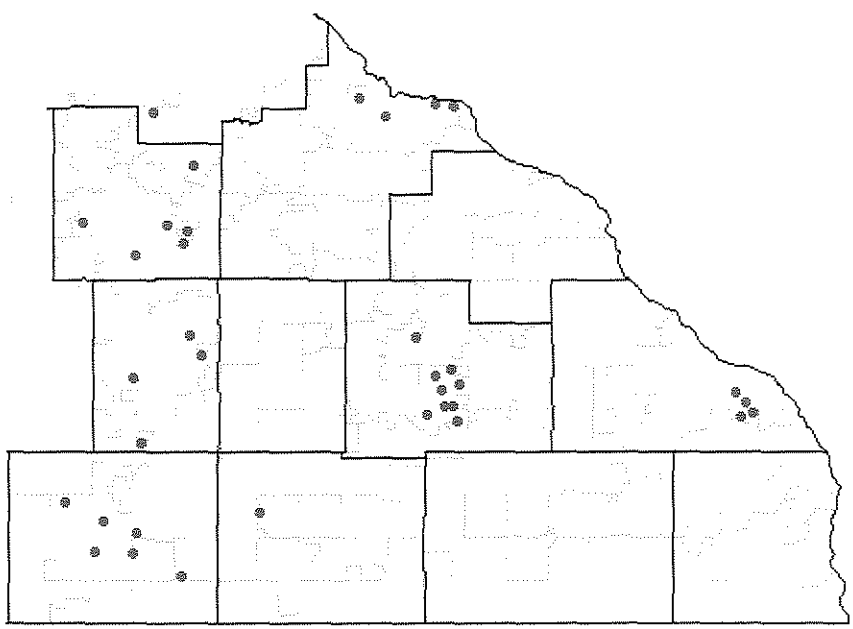


Exhibit III.D.8(b)
Comparison of Female FFS Members per OB/GYN in the Southeast Region

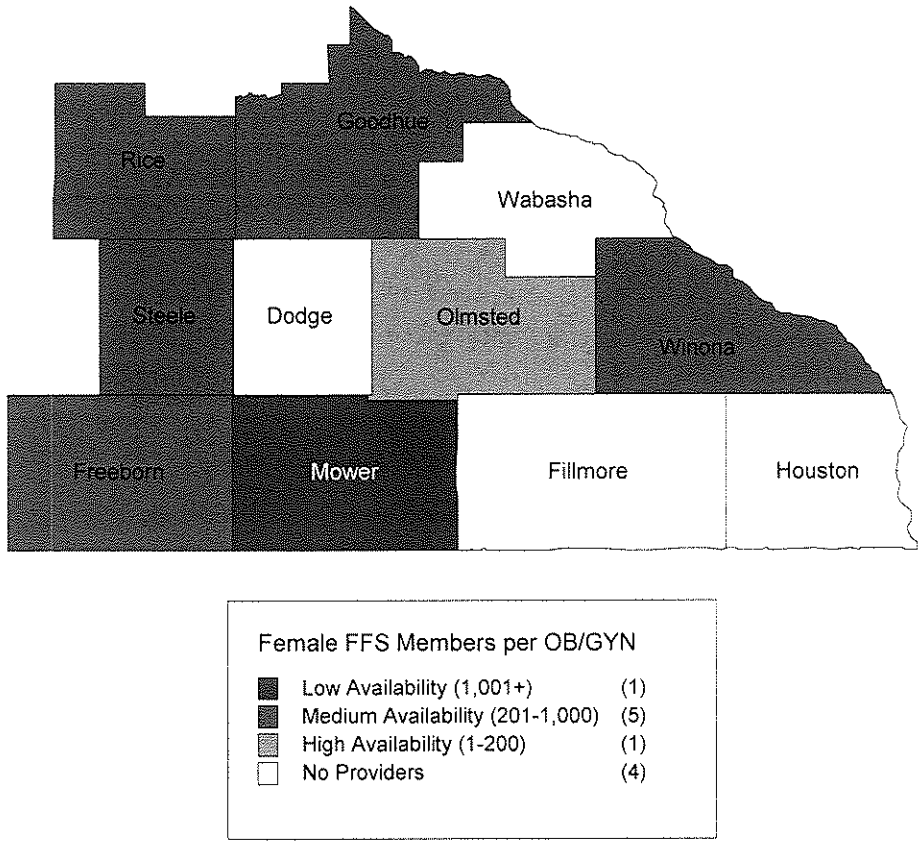


Exhibit III.D.8(c)
OB/GYN Utilization for Female Medicaid FFS Members in the Southeast Region

	Level of Availability to OB/GYNs	Visits per 1,000 Female FFS Enrollees
Statewide		**594**
Region		**723**
Dodge	No Provider	606
Fillmore	No Provider	584
Freeborn	Medium	1,073
Goodhue	Medium	668
Houston	No Provider	349
Mower	Low	738
Olmsted	High	673
Rice	Medium	671
Steele	Medium	812
Wabasha	No Provider	590
Winona	Medium	870

Psychiatrists

Other than Dodge and Fillmore Counties, there is at least one psychiatrist available in each county in the Southeast Region (see Exhibit III.D.8(d) below). But for six counties, availability is considered low; for Freeborn and Steele Counties, it is considered limited; for Olmsted County it is considered high (see Exhibit III.D.8(e) on the next page).

The counties with no psychiatrist available have lower utilization of this service than the other counties in the region, but the remaining counties have a wide range of utilization rates. Overall, the Southeast Region has a utilization rate of 479 visits per 1,000 which is higher than the statewide rate of 433 per 1,000. But this may be weighted by Olmsted County which has a high utilization rate (548 per 1,000). Refer to Exhibit III.D.8(f) on the next page for more details.

Exhibit III.D.8(d)
Density Map of Psychiatrists in the Southeast Region

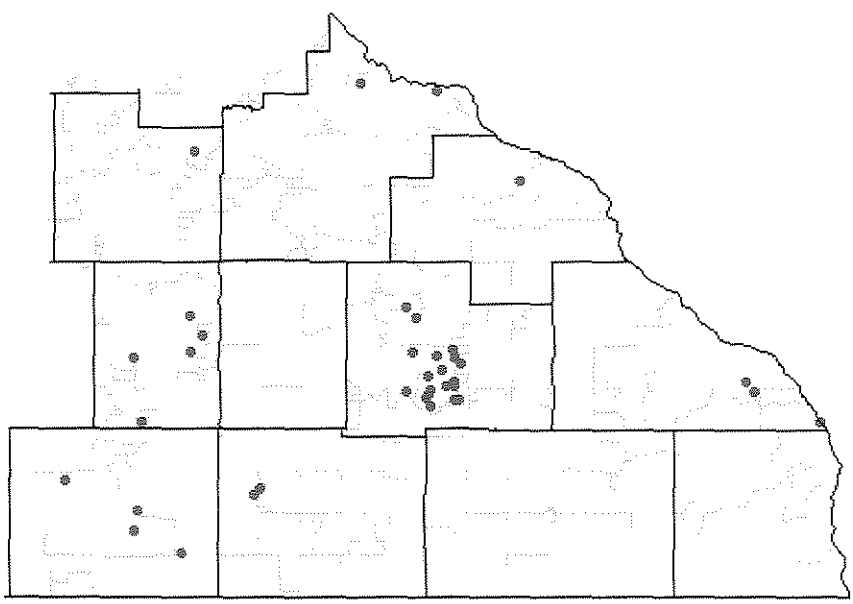


Exhibit III.D.8(e)
Comparison of FFS Members per Psychiatrist in the Southeast Region

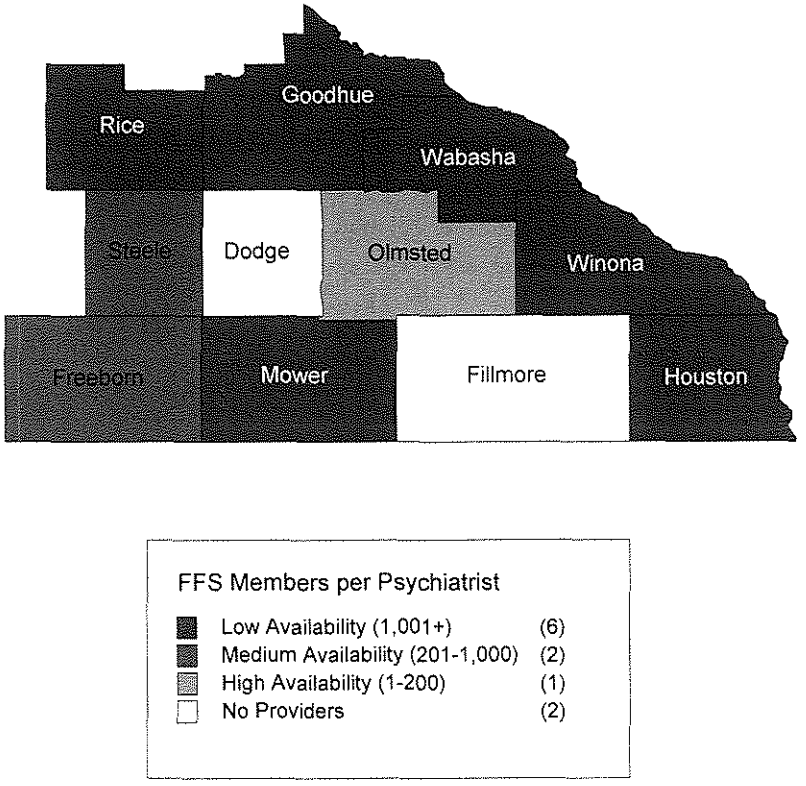


Exhibit III.D.8(f)
Psychiatrist Utilization for Medicaid FFS Members in the Southeast Region

	Level of Availability of Psychiatrists	Visits per 1,000 FFS Enrollees
Statewide		**433**
Region		**479**
Dodge	No Provider	278
Fillmore	No Provider	316
Freeborn	Medium	398
Goodhue	Low	339
Houston	Low	443
Mower	Low	511
Olmsted	High	548
Rice	Low	388
Steele	Medium	556
Wabasha	Low	397
Winona	Low	646

Dentists

Dentists are available to FFS members throughout the Southeast Region and availability of care appears to be spread proportionally based on FFS enrollment. This is because each of the counties in the region are considered medium availability counties for dental services in the state (see Exhibit III.D.8(h) on the next page.

Utilization of dental services for the region are slightly below the statewide average (713 per 1,000 for the region and 743 per 1,000 statewide). The proportional spread of available dentists appears to influence the utilization rates in each county as well. Although there is some variance at the county level, most counties have utilization between 539 and 717 visits per 1,000 enrollees. Refer to Exhibit III.D.8(i) on the next page for more details.

Exhibit III.D.8(g)
Density Map of Dentists in the Southeast Region

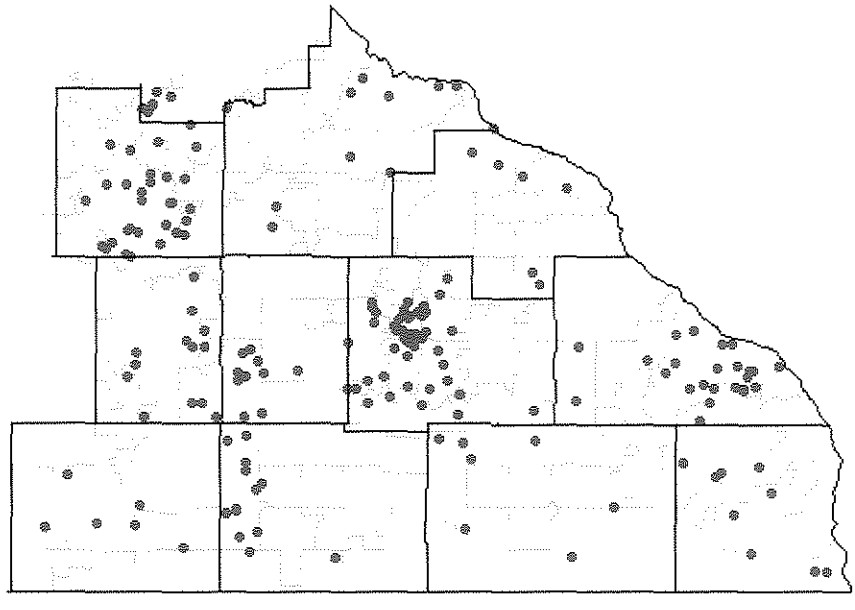


Exhibit III.D.8(h)
Comparison of FFS Members per Dentist in the Southeast Region

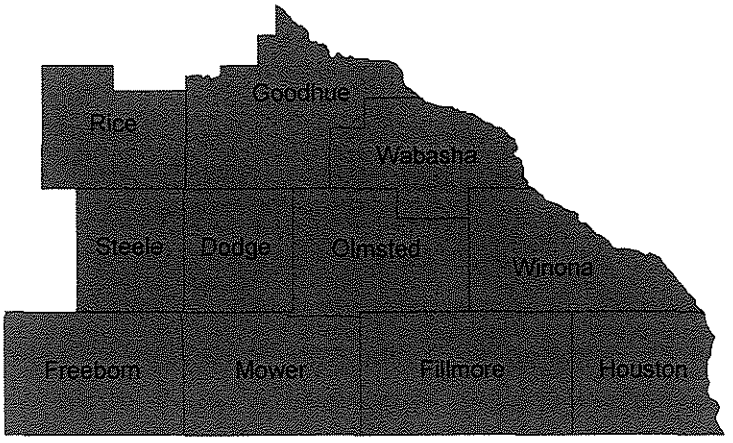


Exhibit III.D.8(i)
Dentist Utilization for Medicaid FFS Members in the Southeast Region

	Level of Availability to Dentists	Visits per 1,000 FFS Enrollees
Statewide		**743**
Region		**713**
Dodge	Medium	541
Fillmore		554
Freeborn	Medium	691
Goodhue	Medium	612
Houston	Medium	788
Mower	Medium	822
Olmsted	Medium	539
Rice	Medium	984
Steele	Medium	717
Wabasha	Medium	645
Winona	Medium	1,025

Cardiologists, Neurologists and Orthopedic Surgeons

All of the regions in the state have reported a wide range among their counties of utilization of cardiologist, neurologist and orthopedic surgeon services. The Southeast Region, though varied to some degree, appears to cluster around the region's utilization average than other regions (see Exhibit III.D.8(j) below). Since utilization is reported by the county location of the member and not the county location of the provider, this relative consistency among counties in the Southeast Region may be due to FFS member's proximity to Rochester where many of these specialists reside.

Exhibit III.D.8(j)
Utilization for Medicaid FFS Members in the Southeast Region Among Other Specialists

	Provider Specialty Located in County?			Claims Per 1,000 FFS Enrollees		
	Cardiologist	Neurologist	Orthopedic Surgeon	Cardiologist	Neurologist	Orthopedic Surgeon
Statewide				**162**	**121**	**127**
Region				**148**	**103**	**98**
Dodge	No	No	No	143	88	87
Fillmore	No	No	No	130	129	82
Freeborn	Yes	Yes	Yes	114	55	99
Goodhue	No	No	Yes	164	113	124
Houston	No	No	No	93	162	94
Mower	No	No	Yes	113	68	75
Olmsted	Yes	Yes	Yes	215	147	110
Rice	No	Yes	Yes	126	82	92
Steele	No	No	Yes	91	68	126
Wabasha	No	No	No	152	88	101
Winona	No	No	Yes	88	72	63

SECTION IV: RECOMMENDATIONS

Availability of care for enrollees in the Medical Assistance fee-for-service program varies significantly across the state. This is true for both primary care services as well as the specialty provider services considered in this study. In general, it was found that availability of dentists was better than availability of physician services throughout state. It was also found that, in most regions of the state, limited availability could result, but did not always result, in lower utilization of services. Specifically, counties designated as having low availability for FFS members to primary care providers often had lower primary office visit utilization (measured on a per 1,000 member basis) than the statewide average but these same counties had lower ER utilization per 1,000. This suggests that potentially lower availability does not equate to lower access to care. Conversely, counties with potentially higher availability did not always yield higher office visit utilization.

This report is one of many that Burns & Associates is completing for the Minnesota Department of Human Services, Health Services and Medical Management Division. Another report already completed showed that physician rates in Minnesota's FFS program are considerably lower than other states. Rate increases alone may not yield improved availability of services for members. Results from a survey of physicians and members in areas of the state that are underserved are discussed in a separate report. This report yields more feedback as to why availability may be limited. The following recommendations are made for consideration to complement other recommendations previously made in this study.

1. The FFS population is proportionally higher in rural areas of the state. Likewise, availability of both primary care services as well as specialists (e.g. OB/GYN, psychiatrists, cardiologists, neurologists, and orthopedic surgeons) that are used considerably by the FFS population is weaker in the rural areas. Although an increase is merited to physician rates across-the-board, consideration should be given to providing an upward adjustment (e.g. 10%-20% increase above the base rate) for physicians in rural areas to incentivize participation.

2. In light of current economic conditions and budget restrictions, an across-the-board rate increase to physicians may not be feasible. Therefore, the highest priority should be given to increasing the rates for evaluation and management services in the office setting to both encourage participation among primary care physicians as well as to reduce inappropriate ER usage.

3. There are a significant number of primary care providers who, though technically participate to some degree in the FFS program, do so at a limited level. The findings from this study showed that availability among "active" FFS primary care providers is problematic. When all potential FFS providers are considered, many of the availability problems were removed. Targeted rate increases alone may help in the regions where the active FFS providers as a proportion of total providers are low. But the results of the provider survey should also be studied to determine if there are factors other than reimbursement rate that are limiting providers' participation that can be addressed (e.g. time from billing to payment, authorization requirements, etc.)

4. Among the highest priority for rate increases in addition to primary care office visit services is office visit services provided by OB/GYNs and psychiatrists. Particularly

in the western regions of the state, the availability of these providers is very limited. If it is found that there are not enough providers even present in these rural counties to offer the services, consideration should be given to increase reimbursement to providers outside the regions to provide services there on a limited basis (e.g. twice per month). If this is done, the rate paid to these out-of-region providers needs to consider the time incurred by the providers to travel to and from the specific region that they will serve on a part-time basis.

5. There are primary care providers that participate in the Medical Assistance managed care program but not the FFS program. Specific outreach should be made to these Medicaid providers to determine what would incentivize them to participate in the FFS program as well.

APPENDIX D

Report to the Legislature: Compilation of Findings from the Surveys Conducted of Providers and Recipients in the Medicaid Fee-for-Service Program

Deliverable #5 under CFMS Contract #B23431

April 30, 2009

BURNS & ASSOCIATES, INC.

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LISTING OF EXHIBITS

EXECUTIVE SUMMARY

The Office of the Legislative Auditor (OLA) issued a February 2008 report "Financial Management of Health Care Programs" which covered, among other items, state payment rates for health care programs. The OLA concluded in its report that the Legislature and the Department of Human Services (DHS) have not taken sufficient steps to address concerns about the adequacy and equity of Minnesota's fee-for-service rates. Specifically, the OLA recommended:

- DHS should report to the 2009 Legislature on the adequacy of Minnesota's fee-for-service provider rates. As part of this analysis, DHS should identify service areas or regions of the state in which public program enrollees have had difficulty accessing providers.

- This report must include recommendations to increase rates as needed to eliminate identified access problems.

- The Legislature should consider increasing fee-for-service payment rates for certain types of providers, such as primary care physicians.

Background

Other than a one-time across the board increase of 3% in 2000, physicians in the Medicaid fee-for-service (FFS) program have not received a rate increase since the rates were originally set in 1992. The 1992 fee-for-service rates were set at the median 1989 physician charges reduced by 20% (for most primary care services) or 25% (all other services). Since there have been essentially no rate adjustments since 1992, payments for office visits, maternity care and preventive medicine have deteriorated to 33% of charges (versus 62% in 1993) and to 31% of charges (versus 58% in 1993) for other physician services.

In December 2008, the DHS retained Burns & Associates, Inc. (B&A), a health care consulting firm who works primarily with state Medicaid agencies, to perform an independent evaluation of the fee-for-service provider rates. B&A was charged to:

1. Compare the FFS provider rates paid by DHS to other states' Medicaid rates

2. Examine FFS rates paid to physicians and non-physicians who deliver the same service

3. Investigate the availability of providers to FFS participants, with a focus on physician services, and report the results by region and provider specialty to determine if FFS payment rates are influencing participants' availability to practitioners

4. Survey physicians and participants in the Minnesota Health Care Program (the FFS program) and report on perceptions of limitations in members' access to care as a result of the current fee structure

This deliverable reports the results of the survey conducted of members enrolled in the FFS program and, separately, the results of the survey conducted of physicians participating in the FFS program.

Methodology

Physician Survey

A 15-question survey was developed to gather more information from providers regarding their satisfaction with the current rates of reimbursement and the administration of the FFS program. The survey asks providers to rank the factors that might limit their participation in the program and for specific rate increases that would best encourage greater program participation.

The survey was piloted with a selection of providers that were invited by the Minnesota Medical Association (MMA) to participate. MMA members were also invited to complete a survey even if they were not included in the original sample that was sent surveys.

B&A surveyed 1,100 in-state physicians (out of 9,638) with varying levels of participation in the FFS program. Providers in rural areas were oversampled in order to obtain feedback from regions with lower availability of providers in the state. The survey was sent out by mail in two waves. The first wave was sent to all 1,100 providers on March 10 with a request for responses by March 26. However, survey responses were accepted through April 26. Self-addressed, stamped return envelopes were provided. Due to a less-than-desired response rate, a second wave of the survey was sent out to all physicians that did not respond to the first wave. This second wave was sent out on March 31 with a response due date of April 17.

Address information was obtained from DHS for the physician survey. B&A received 149 surveys back due to an incorrect address or change in address with no forwarding information available. A total of 148 mail surveys were submitted to B&A. Therefore, of the net 951 surveys sent with a positive address, the response rate was 16 percent. An additional 13 were faxed to B&A by providers who were not sent a survey originally but had expressed interest to the MMA in participating. For most of the analyses, however, B&A was only able to use 97 of the survey responses due to incomplete surveys or lack of knowledge/interest of hospital-based physicians for questions related to reimbursement.

Member Survey

A total of 561 individuals (out of 16,250 potential recipients) participating in the Medicaid FFS program were sent a member survey. This 12-question mail survey asks members questions regarding items such as the period of time to obtain an appointment at a doctor's office, the wait time upon arrival at the office, and the level of difficulty faced in finding a primary care provider, specialist or dentist. The sample that was surveyed included in-state residents who had seen one of the physicians sent a provider survey.

B&A intended to survey 800 FFS members. However, the sample was reduced due to incurred or missing address on the DHS file, the member's death, or loss of Medicaid eligibility since December 2008. One wave of the survey was mailed out on March 12 with a request for responses by March 30.

Even after running this test, 24 surveys were returned to B&A due to incorrect address. There were 128 responses submitted to B&A. Therefore, of the net 537 surveys sent with a positive address, the response rate was 24 percent.

Findings

Related to the Member Survey

- When members were asked if they had a personal doctor or nurse they see most of the time, 87% of respondents indicated that they did.

- Almost two-thirds of the respondents had seen their primary doctor three or more times during a recent nine-month period. More than half had seen another physician in the practice where their primary doctor works. More than half had also visited another doctor's office or clinic during this time period (such as a specialist).

- Over half of the members were able to obtain an appointment with their primary doctor when they needed care right away within one day and over three-quarters were able to obtain an appointment within two days. Findings were similar when asked about appointments at an office or clinic other than at the member's primary doctor office.

- For routine appointments, about half of members said that they could obtain a routine appointment within a week either at their primary doctor's office or at another doctor's or clinic office.

- Over 40% of the members who responded to the question (44 out of 103) regarding use of alternative locations to the doctor's office indicated that they had used the hospital emergency room if they needed care right away. However, the majority of these members had only used the ER once or twice in the last nine months. B&A found a disproportionately higher response for ER usage among members in the Northeast Region of the state.

- When they went to see their primary doctor, more than half of the members (55%) reported waiting 15 minutes or less beyond the scheduled appointment time and over three-quarters (77%) waited less than 30 minutes.

- Members were asked the level of difficulty in finding different physician specialty types as well as dentists. Respondents could indicate if it was a 'big problem', 'small problem', 'no problem', or that they did not try to find the particular physician type. There were only two provider types that a majority of the respondents provided feedback on—personal doctor or nurse (90 respondents, or 70% of the total) and dentists (87 respondents, or 67% of the total). Eighty percent of the respondents indicated no problem in finding a personal doctor or nurse, but only 54 percent indicated no problem in finding a dentist. When analyzed at the regional level, the difficulty in finding a dentist was concentrated in the northern and central parts of the state. Whereas the percentage of respondents reporting a 'big problem' in finding a dentist was 32% statewide, it was 63% in the Northeast Region, 67% in the Northwest Region, and 69% in the Central Region.

- Over 60% of survey respondents stated that they were 'very satisfied' and over 80% were either 'very satisfied' or 'somewhat satisfied' with the services they receive in the Medical Assistance program. Almost three-quarters of respondents (73%) believe that their ability to receive care in the Medical Assistance program is either the same or better than what they would receive with private insurance.

Related to the Physician Survey

- Among the 97 respondents used in the analysis, 13% stated that they had a solo practice, 58% stated that they were a member of a group practice, 23% stated that they were a salaried physician, and 5% did not answer the question.

- The majority of the respondents participate in both the Medicaid FFS program and the Medicaid managed care program—61% contract with a Medicaid managed care plan, 14% do not contract, and 25% did not answer the question. However, for almost half of the respondents, the Medicaid program (both FFS and managed care) represents less than 10% of their total business.

- Of the 83 physicians that responded to the question, only seven indicated that they limited their participation in the Medicaid FFS program. Of these, six of the seven cited reimbursement rates as the top reason.

- Physicians were asked to review a rate schedule that was provided with the survey which included the highest-volume service codes billed by physicians. When asked to estimate the level that the rates would need to be increased to cover their costs to deliver the services to Medicaid FFS members, over one quarter (28%) of the respondents indicated that the rates would need to at least be doubled, while over 80% stated that the rates needed to be increased by 40 percent or more.

- When asked for their satisfaction level about the rates shown on the survey's rate schedule, 89% of the respondents expressed dissatisfaction with the rates and 73% were very unsatisfied. For other low-volume rates, the dissatisfaction rate was almost as high at 84%. No respondent indicated that they were 'very satisfied' with the rates for high-volume services, and only one respondent stated this for the low-volume service rates.

- Physicians were also asked to provide their opinion on Medicaid FFS rates overall as compared to other payers. Among the various payers queried, the Medicaid FFS program had the highest level of dissatisfaction (77% very unsatisfied and 13% somewhat unsatisfied), but the Medicaid managed care program was at almost the same level of dissatisfaction (70% very unsatisfied and 20% somewhat unsatisfied). This contrasts with the satisfaction levels of commercial payers. Physicians rated their satisfaction level with commercial managed care rates (very or somewhat satisfied) at 74% and with non-managed care commercial rates at 81%.

- Respondents were asked to provide the name of a service or specific codes that they would suggest receive priority if funding was limited to increase physician rates. Over half of the 79 respondents who provided suggestions suggested that the evaluation and management (E&M) codes, which are the high-volume service codes delivered by primary care providers, be given top priority.

- Physicians were also asked about their satisfaction with other aspects of the FFS program, including billing, prior authorization, and referrals to specialists. None of the items queried received a satisfaction rating above 50% except for 'range and number of specialists available for referrals' which received a 59% satisfaction rating. Items related to prior authorizations and claims denials each received a dissatisfaction rating among 67% of the respondents ('very unsatisfied' and 'somewhat unsatisfied' combined).

Recommendations

The intent in surveying a sample of Medicaid FFS members and providers was to gain on-the-ground feedback related to topics previously analyzed in other reports that have been submitted by Burns & Associates (B&A) for this engagement. Although the sample of respondents was small, particularly for the provider survey, the feedback from both the members and the physicians supported many of the topics studied. In summary:

- It was generally found that members' access to physicians in the FFS program was sufficient, though there may be pockets in the northern counties of the state where access may be compromised. This was supported by members' feedback on the survey reporting reasonable wait times to make an appointment for urgent care and routine care.

- The only provider type for which there appears to be access concerns in multiple parts of the state is for dentists.

- Physicians almost universally believe that their reimbursement is very unsatisfactory in the Medicaid FFS program. Their level of satisfaction was lowest for Medicaid FFS when compared to other payers as well. Although few have stated that they have outright limited the number of FFS patients that they will accept, many reported that they are considering it.

- Over one quarter (28%) of the physicians indicated that the rates would need to at least be doubled, while over 80% stated that the rates needed to be increased by 40 percent or more, just to cover their costs. The majority of physicians that provided specific areas for rate increases stated that the high-volume evaluation and management services should be given highest priority. These comments are supported by a recent national study which showed that Minnesota ranked 43rd among Medicaid agencies for its payment for primary care services and 45th for obstetrical services. When compared to Medicare rates, Minnesota fares equally poorly for primary care and obstetrical services, but is ranked high compared to other states for non-primary, non-OB services.

In light of these findings and the feedback from its constituents, B&A recommends that the Minnesota Department of Human Services (DHS) adopt the Medicare Resource-Based Relative Value Scale (RBRVS) as per Legislative mandate. Resources should be put towards implementation of this system as a base for further rate changes. The RBRVS system is a national standard of reimbursement that virtually all physicians understand, is regarded as having equitable resource use factors for the various physician services, and is relatively easy to administer.

Since it is unlikely in the current economic situation that the state can afford physician payments at the Medicare rates, the conversion factor that is used in the RBRVS system should be set at a level that will be budget neutral overall. However, B&A recommends that the state adopt a policy goal of compensating physicians at a specified level, such as 85% of the Medicare rates. As funding becomes available, the conversion factor can be increased accordingly to meet this target.

As a policy matter, the DHS may want to adopt a higher conversion factor for "high value" services, which we recommend should initially include evaluation and management physician services as well as obstetrical/prenatal care services. This will encourage participation among primary care physicians and can help towards the long-term goal of reducing inappropriate ER use.

SECTION I: INTRODUCTION

The Minnesota Department of Human Services (DHS), Health Services and Medical Management Division (HSMMD) retained Burns & Associates, Inc. (B&A) to evaluate the adequacy of current rates and the availability of services (primary care and selected specialties) for fee-for-service (FFS) participants enrolled in the Minnesota Health Care Program (MHCP).

B&A is an independent health care consulting firm who works primarily with state Medicaid programs. Under this engagement, B&A was tasked with completing four separate reports at the request of the DHS as well as a compilation of findings in a final report to be delivered in May 2009. This is the fourth and final stand-alone report, namely Deliverable #5: *Compilation of Findings from the Surveys Conducted of Providers and Recipients in the Medicaid Fee-for-Service Program*. Other reports previously delivered include:

- Report to the Legislature: Comparison of Minnesota Medicaid Fee-for-Service Physician Rates to Rates Paid by Medicare and Selected Other States
- Report to the Legislature: Comparison of Payment Rates for Services Delivered by Physicians and Non-Physicians in the Medicaid Fee-for-Service Program
- Report to the Legislature: Evaluation of Availability of Physician Services in the Minnesota Medicaid Fee-for-Service Program

The Office of the Legislative Auditor (OLA) issued a February 2008 report "Financial Management of Health Care Programs"[1] which covered, among other items, state payment rates for health care programs. The OLA concluded in its report that the Legislature and the Department of Human Services (DHS) have not taken sufficient steps to address concerns about the adequacy and equity of Minnesota's fee-for-service rates. Specifically, the OLA recommended:

- DHS should report to the 2009 Legislature on the adequacy of Minnesota's fee-for-service provider rates. As part of this analysis, DHS should identify service areas or regions of the state in which public program enrollees have had difficulty accessing providers.
- The Legislature should consider increasing fee-for-service payment rates for certain types of providers, such as primary care physicians.

Minnesota's physicians are paid for services delivered to the FFS (non-managed care) population at the lower of either:

1. Their submitted charge, or
2. The median rate established in 1992 using 1989 data that is discounted 20% (for evaluation and management or OB/GYN services) or 25% (for all other services).

Other than a one-time across the board increase of three percent in 2000 and a rate increase for mental health services when provided by a psychiatrist, physicians have not received rate increases since the

[1] The OLA report can be found at: http://www.auditor.leg.state.mn.us/ped/pedrep/healthcare.pdf
The discussion of fee-for-service rates is on pages 49-53 of the report.

1989 base year data was utilized. Since there have been essentially no rate adjustments since 1992, payments for office visits, maternity care and preventive medicine have deteriorated to 33% of charges (versus 62% in 1993) and to 31% of charges (versus 58% in 1993) for other physician services.

A study just released that compares state Medicaid FFS payment rates to each other and to the Medicare program for physician services showed that Minnesota is tied for 43rd among states in the relative ranking of Medicaid rates for primary care services and ranked 45th among states for obstetrical service rates.[2] An index was also established to compare each state Medicaid FFS program's rates to the Medicare program rates. Minnesota ranked 41st among states on this index for primary care and tied for 41st among states for obstetric care. For non-primary and non-obstetric services, however, Minnesota ranks 5th among the states. These comparisons utilize rates published by each state agency but do not include any special pricing considerations that may be in place at each state. To the extent that special pricing considerations are not reflected in base rates compared, the state rankings may be skewed.

This report focuses on the results of feedback from physicians regarding their perceptions of the reimbursement they receive in the Medicaid FFS program as well as other items that may inhibit further participation in the program. The report also reports on feedback from participants in the FFS program and their perceptions of the ability to access care from physicians as well as other feedback on the FFS program as a whole.

[2] Zuckerman, S., Williams, A., & Stockley, K. Trends in Medicaid Physician Fees, 2003-2008. *Health Affairs* 28, no. 3 (2009). Published online 28 April 2009.
http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.3.w510

SECTION II: METHODOLOGY

This section summarizes the methodology used to develop the sample of Medicaid fee-for-service (FFS) physicians to survey and the sample of FFS members to survey. An overview of the survey tool development and the timing for administering the survey is also discussed.

Physician Survey

A 15-question survey was developed to gather more information from providers regarding their satisfaction with the current rates of reimbursement and the administration of the FFS program. The survey asks providers to rank the factors that might limit their participation in the program and for specific rate increases that would best encourage greater program participation.

The survey was piloted with a selection of providers that were invited by the Minnesota Medical Association (MMA) to participate. Feedback generated from this pilot was used to adjust the questions based on the interest in gathering specific information that was of interest to both the MMA and the Department of Human Services (DHS). A copy of the survey tool appears in Appendix A.

A sample of 1,100 providers was generated by identifying in-state physicians participating in the FFS program with specialties in five areas: primary care, cardiology, OB/GYN, orthopedic surgery and neurology. Physicians in these specialties that were used in other analyses (e.g. the reports on provider availability and the comparison of Minnesota rates to other Medicaid programs) were included. The total number of potential in-state providers to draw the sample from consisted of 9,638 providers.

Half of the providers drawn for the sample were identified as actively-participating providers. These providers are defined as a physician that billed on average three or more claims per month in the FFS program in State Fiscal Years (SFY) 2007 and 2008. The other half of the sample was drawn from providers that were defined as limited-participating providers. These are physicians that billed some services in SFYs 2007 and 2008 to the FFS program but less than the average of three claims per month used to define actively-participating providers. The two subgroups were selected to determine if perceptions of reimbursement were different between those that regularly participate in the FFS program and those that do not.

Burns & Associates, Inc. (B&A) slightly oversampled providers in rural areas in order to obtain feedback from regions with lower availability of providers in the state. Our report on physician availability in the FFS program divided the state into eight regions. Findings related to the number of actively-participating and limited-participating physicians in each region are discussed in that report. Of all actively-participating providers, 61% are located in the Metro Region. However, the survey sample was limited to include only 50% of active providers in the Metro Region. Limited-participating providers are heavily concentrated in the Metro Region (42%) and Southeast Region (40%). The sample of limited providers was drawn such that 36% of providers were in the Metro Region and 10% in the Southeast Region. The remaining six regions were slightly oversampled.

Providers that were sent the survey included 550 actively-participating providers and 550 limited-participating providers. Other than the oversampling of rural providers, the samples were generated randomly and are representative of the pool of 9,638 in-state providers.

The survey was sent out by mail in two waves. The first wave was sent to all 1,100 providers on March 10 with a request for responses by March 26. However, survey responses were accepted

through April 26. Self-addressed, stamped return envelopes were provided. The Minnesota Medical Association provided a notice of endorsement in its weekly newsletter shortly after the survey was released to encourage participation from its members. Physicians who were not selected in the sample who wanted to participate were emailed a survey upon request. Due to a less-than-desired response rate, a second wave of the survey was sent out to all physicians that did not respond to the first wave. This second wave was sent out on March 31 with a response due date of April 17.

Address information was obtained from DHS for the physician survey. B&A received 149 surveys back due to an incorrect address or change in address with no forwarding information available. These physicians, 43 actively-participating and 106 limited-participating, were removed from the counts for further analysis discussed in Section III.

Member Survey

A total of 561 individuals participating in the Medicaid FFS program were sent a member survey. This 12-question mail survey asked members questions regarding items such as the period of time to obtain an appointment at a doctor's office, the wait time upon arrival at the office, and the level of difficulty faced in finding a primary care provider, specialist or dentist. A copy of the survey tool appears in Appendix B.

The pool of potential FFS members included those who:

- Had obtained a service with at least one of the 1,100 providers in the provider survey sample during Calendar Year (CY) 2008,
- Were living in Minnesota as of December 2008,
- Were in the FFS program for at least three consecutive months in 2008, and
- Were identified on the DHS file as not needing interpreter services.

These requirements generated a list of 16,250 potential members in the FFS population.

Of the 16,250 FFS members, 800 were selected to receive the member survey. Those who visited a limited-participating provider in CY 2008 were oversampled. The total population of FFS members who saw a limited-participating provider was eight percent; however, B&A oversampled to make this subgroup 20% of our total sample. Otherwise, the sample was randomly selected across regions of the state. The members who saw a physician designated as limited-participating were oversampled to understand if there were specific concerns related to access to care.

Address information was obtained from DHS for the member survey. Although 800 members were selected in the initial sample, current addresses were only found for 561 of these members. Patient and claims data were used to generate the sample of 800 as of December 2008, but members were removed due to death or no longer eligible for the program as of when address information was sought in March 2009. Even after running this test, 24 surveys were returned to B&A due to an incorrect address. These were removed from the analyses shown in Section III.

One wave of the survey was mailed out on March 12 with a request for responses by March 30. Returned surveys were accepted through April 26.

SECTION III: FINDINGS

Member Survey

Of the 561 surveys sent to Medicaid fee-for-service (FFS) members, 128 were submitted to B&A and 24 were returned to sender. Therefore, of the net 537 surveys sent with a positive address, the response rate was 24 percent.

A profile of the demographics for the respondents in Exhibit 1 shows that the proportion of respondents by gender was similar to the total surveyed. A higher proportion of older members (age 40-64) responded than were surveyed while a lower proportion of younger members (age 29 and under) responded. Parents were asked to indicate if they were responding on behalf of their child, but these responses were counted in the Under Age 19 group. By region, the respondents were distributed very similar to the total surveyed with the exception of the Metro Region which was slightly under represented among the respondents (32% of respondents versus 39% of those surveyed).

Exhibit 1
Demographics of Respondents to the Member Survey

	Number of Respondents	Percent of Respondents	Total Surveyed	Percent of Surveyed
Gender				
Female	70	55%	313	58%
Male	58	45%	224	42%
	128	100%	537	100%
Age Group				
Under Age 19	36	28%	195	36%
Age 19 - 29	17	13%	108	20%
Age 30 - 39	18	14%	63	12%
Age 40 - 64	56	44%	166	31%
Age 65 and over	1	1%	5	1%
	128	100%	537	100%
Region				
Northeast	15	12%	58	11%
Northwest	13	10%	63	12%
Central	20	16%	83	15%
West Central	7	5%	20	4%
South Central	9	7%	36	7%
Metro	41	32%	209	39%
Southeast	12	9%	33	6%
Southwest	11	9%	35	7%
	128	100%	537	100%

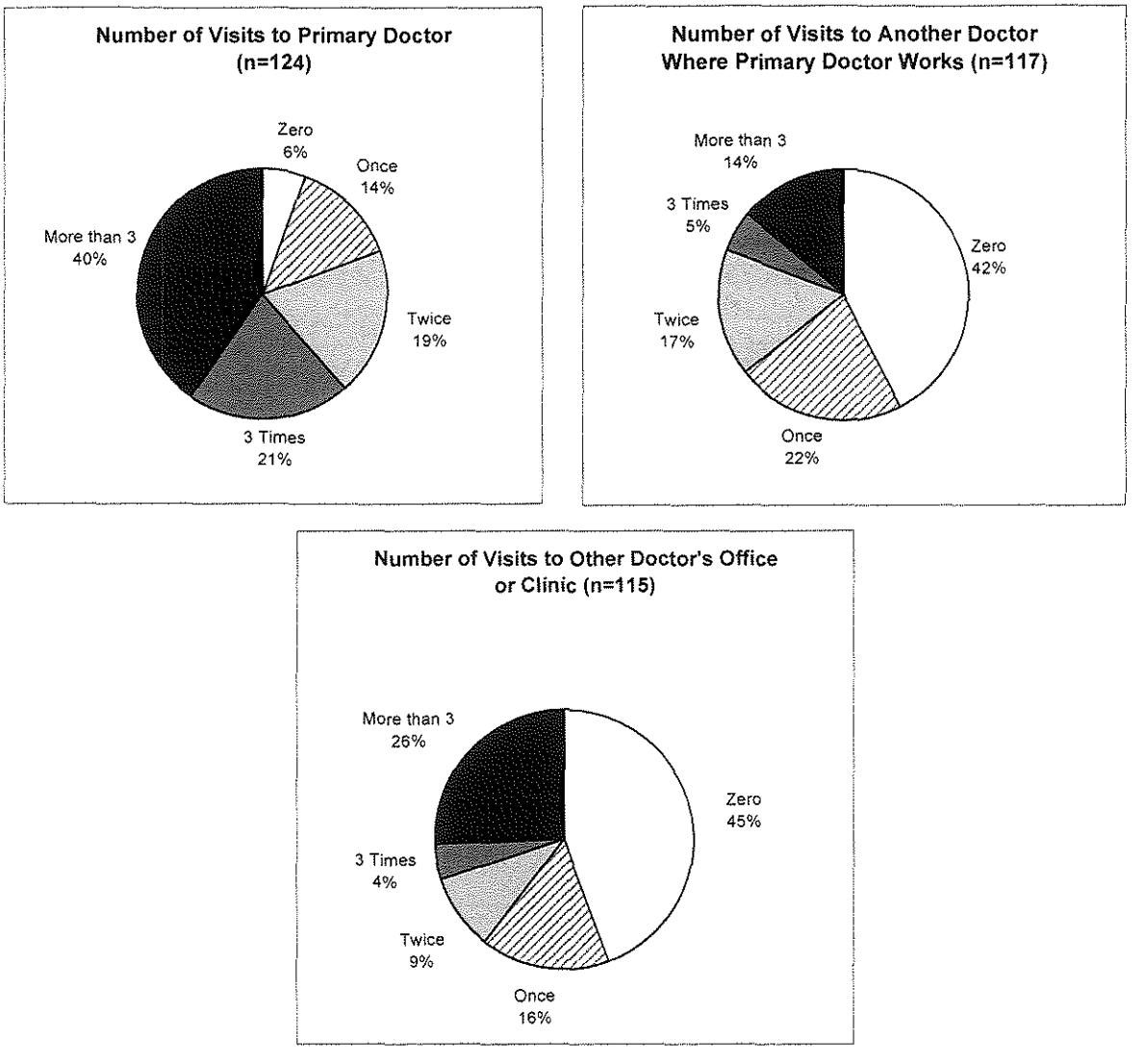
Physician Relationship and Frequency of Visits

Members in the FFS program may see any doctor under contract with the Medical Assistance program. When members were asked if they had a personal doctor or nurse they see most of the time, 87 percent of respondents (105 out of 121) indicated that they did (seven members did not answer the question). Fourteen of the 16 members who did not have a personal doctor or nurse indicated that they usually went to a clinic.

Members were asked about their frequency of visits to their primary doctor or to other physicians. Over a nine-month period (July 2008 – March 2009), almost two-thirds of the respondents had seen their primary doctor three or more times. More than half had seen another physician in the practice where their primary doctor works. More than half of the respondents had also visited another doctor's office or clinic during this time period. This may include specialists.

Exhibit 2

Since last July, how many times did you visit the following for care?



Appointment Scheduling

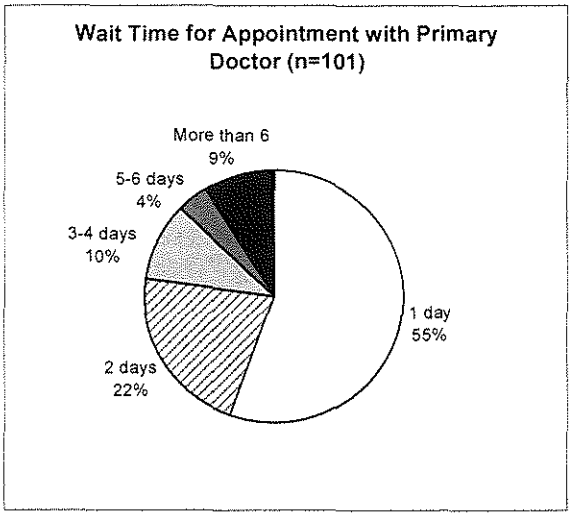
Members were asked the wait time to schedule a doctor's appointment under two scenarios—when they needed care right away and for routine appointments. These questions were asked for situations when the member was seeing their primary doctor as well as other doctors.

Exhibit 3 shows that over half of the members were able to obtain an appointment with their primary doctor when they needed care right away within one day and over three-quarters were able to obtain an appointment within two days. Findings were similar when asked about appointments at an office or clinic other than at the member's primary doctor office.

For routine appointments, about half of members said that they could obtain a routine appointment within a week either at their primary doctor's office or at another doctor's or clinic office (see Exhibit 4). Three-quarters of the members could obtain an appointment within two weeks of inquiring.

Exhibit 3

If you checked more than zero for number of visits, how long did you have to wait for an appointment when you needed care right away?



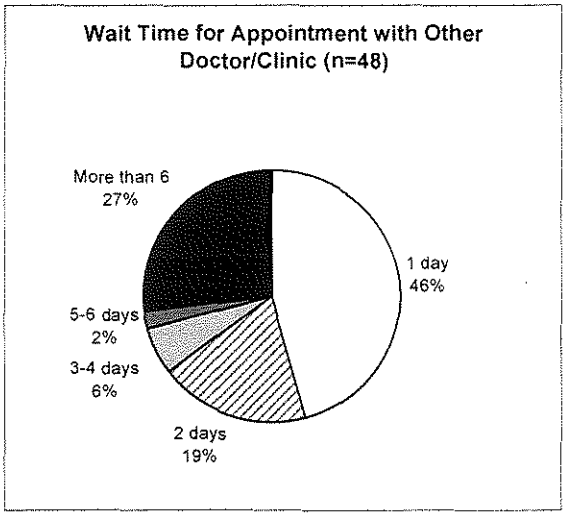
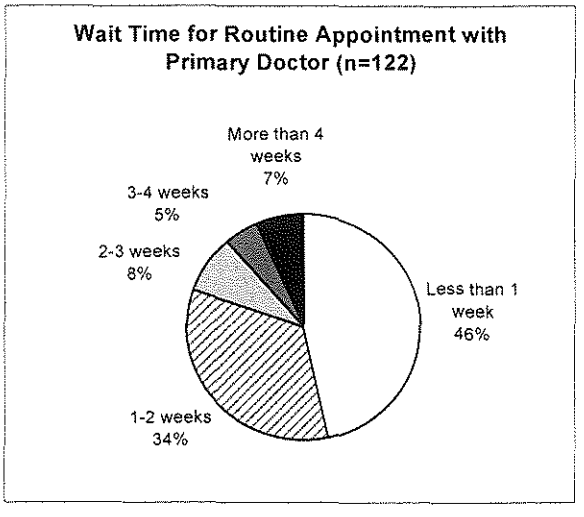
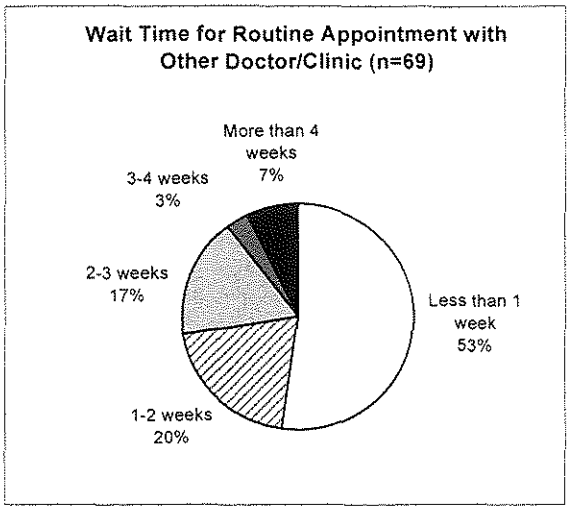


Exhibit 4

On average, how long did you have to wait for a checkup for a routine appointment?





Alternative Sources to Access Care

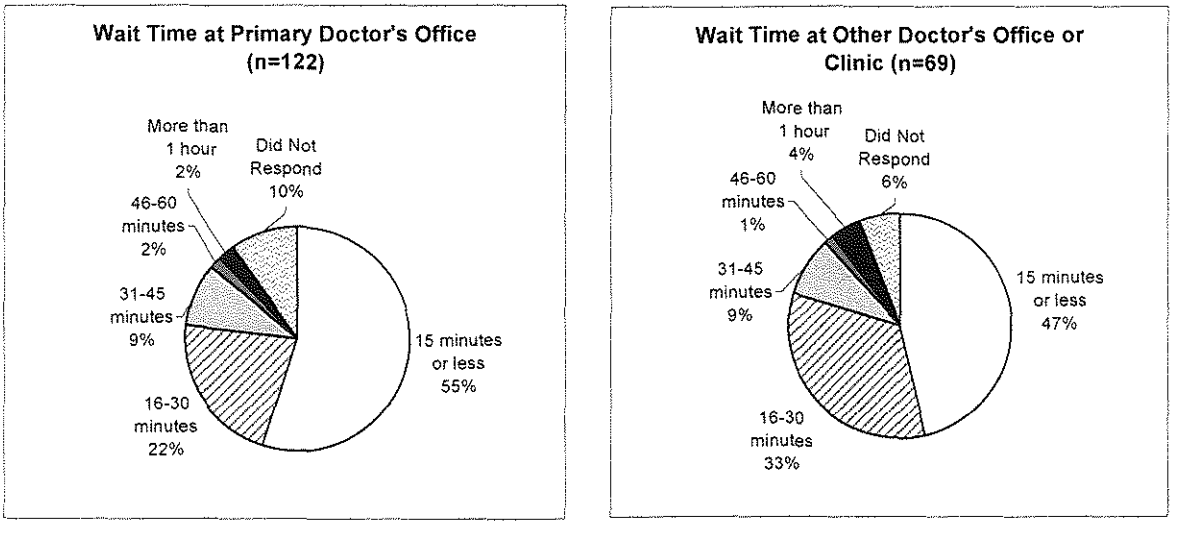
Members were asked if they used alternative sources other than a doctor's office to access care if they needed care right away but felt that the wait time for an appointment at the doctor's office was too long. Over 40 percent of the members responding to this question (44 out of 103) indicated that they had used the hospital emergency room if they needed care right away. One-third of those responding to the question (34 out of 103) stated that they used an urgent care center, while only four members had stated that they used a retail clinic. However, the majority of members who used the ER and urgent care centers in the last nine months had only used it once or twice. B&A analyzed the members who used the ER to determine if there was disproportionate use in one of the eight regions in the state. Members in the Northeast Region did report higher ER usage on a proportional basis (60% in the region versus 43% statewide); however the sample of 15 respondents in the Northeast Region is too small to draw any definitive conclusions related to limitations to access to primary care.

Wait Time at Doctor's Office

Members who had scheduled a routine appointment were also asked how long they waited at the doctor's office after their scheduled appointment time. For members seeing their primary doctor, more than half (55%) reported waiting 15 minutes or less beyond the scheduled appointment time and over three-quarters (77%) waited less than 30 minutes. For other doctors' offices or clinics, the wait times were similar to what was found in the primary doctors' offices.

Exhibit 5

When you went for your appointment, how long after your appointment time did you wait to see the doctor?

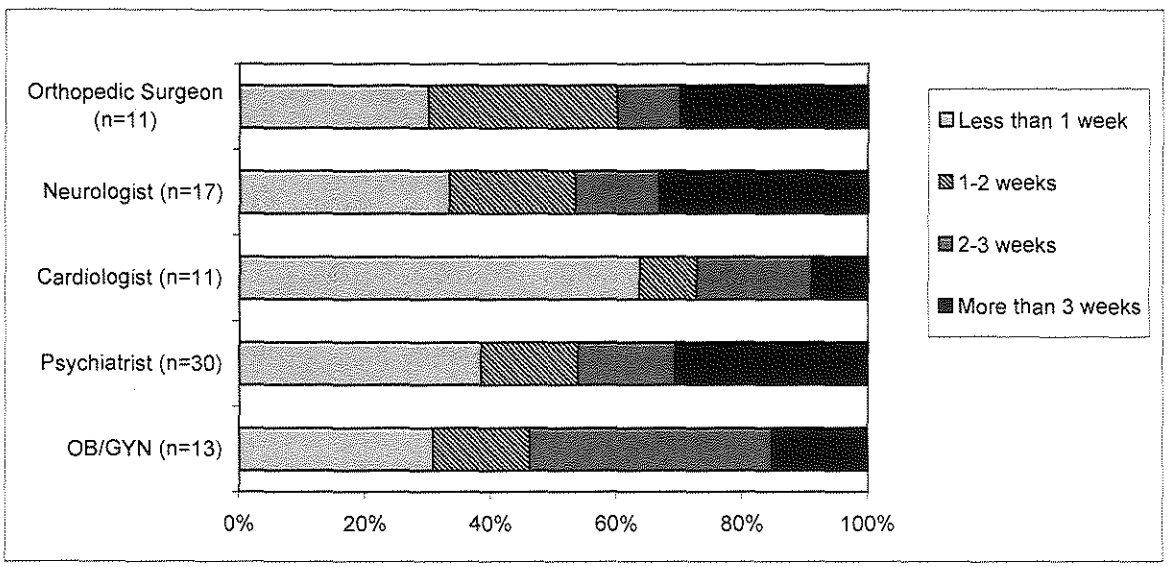


Need for and Access to Specialists

There were 67 FFS members out of 109 responding to the question (61%) who indicated that they needed to see a specialist in the last nine months. Five specialty types were listed on the survey and members were asked if they needed to see one or more of these specialists since July 2008. The need for the selected specialist services was limited, other than psychiatrists, which were needed by 30 of the 128 respondents (23% of total). Members were asked how long it took to obtain an appointment from the point of initial inquiry. Exhibit 6 shows the variation in appointment scheduling for each

specialist; however, the results should be interpreted with caution due to the low sample responding to this question. Between 46% and 60% of the respondents stated that they were able to make an appointment within two weeks for all of the specialists listed except cardiologists. The members reported that it was easier to obtain an appointment with a cardiologist (73% of those inquiring obtained an appointment within two weeks).

Exhibit 6
Need and Wait Time for Selected Specialist Services



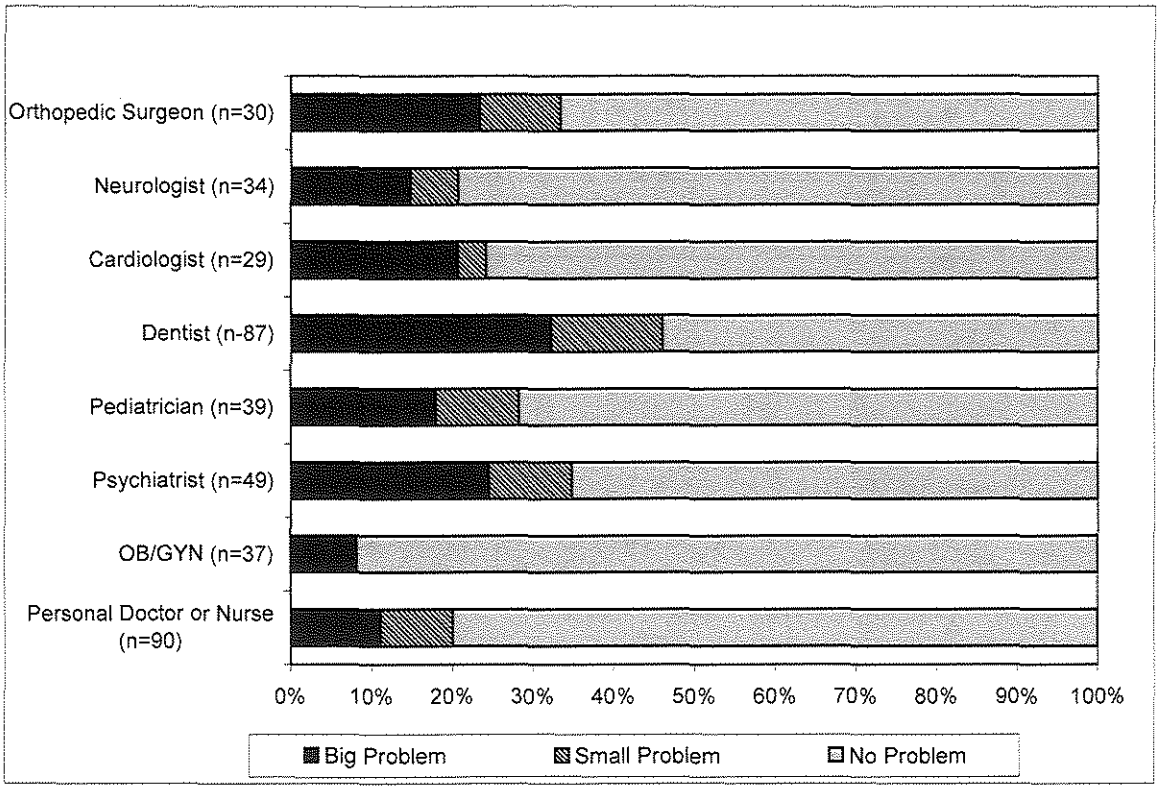
Difficulty in Finding Specific Physician Types

Members were asked the level of difficulty in finding different physician types as well as dentists. Respondents could indicate if it was a 'big problem', 'small problem', 'no problem', or that they did not try to find the particular physician type. The sample sizes shown in Exhibit 7 indicate those that positively responded whether it was or was not a problem in finding the physician type.

There were only two provider types that a majority of the respondents provided feedback on—personal doctor or nurse (90 respondents, or 70% of the total) and dentists (87 respondents, or 67% of the total). Eighty percent of the respondents indicated no problem in finding a personal doctor or nurse, but only 54 percent indicated no problem in finding a dentist. Dentists were also the provider type that the highest percentage of members indicated a 'big problem' in finding (32% of 87 respondents), followed by psychiatrists (24% of 49 respondents). The least concern was expressed by respondents in finding an OB/GYN. Exhibit 7 on the next page provides further details.

When analyzed at the regional level, the difficulty in finding a personal doctor or dentist was concentrated in the northern and central parts of the state. Whereas the percentage of respondents reporting a 'big problem' in finding a dentist was 32% statewide, it was 63% in the Northeast Region, 67% in the Northwest Region, and 69% in the Central Region. Likewise, the statewide average reporting a 'big problem' in finding a personal doctor or nurse was 11%, but it was 33% in the Northeast Region, 36% in the Northwest Region, and 38% in the Central Region.

Exhibit 7
Level of Difficulty in Finding Specific Physician Types



There were 61 respondents (48%) who indicated that it was difficult to find a doctor or dentist. To understand why in particular this was the case, members were asked to select up to two of the following reasons. The results are shown in Exhibit 8.

Exhibit 8
Reasons Offered for Difficulty in Finding a Doctor or Dentist

Reason	Number Responding	Percent of Total (n=128)
Doctor/Dentist would not see me because I have Medical Assistance	40	31%
Doctor/Dentist not taking new patients	28	22%
There are just not enough doctors/dentists where I live	15	12%
There are no doctors/dentists who speak my language	1	1%

When reviewed at the regional level, the Northwest Region's members responded disproportionately to the responses 'would not see me because I have Medical Assistance' (46% of total in the region), 'not taking new patients' (46% of total) and 'just not enough doctors where I live' (38% of total). Members in the Southeast Region also responded disproportionately to 'just not enough doctors where I live' (25% of total in the region).

Qualitative Feedback

Respondents were also given the opportunity to provide their own feedback related to their struggles to access physicians and dentists and other comments on the Medical Assistance program. Of the 128 respondents, 59 provided qualitative feedback. Of these, most were related either to perceived provider bias because they were enrolled with Medical Assistance or general comments on access to physicians and dentists. However, all but one of these comments related specifically to bias from or difficulty in finding dentists. Some of the qualitative comments are provided below.

Related to Perceived Provider Bias

> No problems seeing a pediatrician, [but] most dentists do not see patients with MN care or Medicaid. They don't admit it but just say they have enough Medicaid patients for that month. Only 1 dentist w/in 30 mi. that would take Medicaid.
>
> We have to travel to see dentist that takes MA. They do not do a good job and they have an assembly line mentality with patients.
>
> It is very hard to find a dentist that takes Medicaid. We have to drive 2 hours out of our way to find a dentist that takes Medicaid.
>
> Feel discriminated against because of MA especially getting a dentist.
>
> It would be nice if there were more dentists that would accept Medicaid.
>
> The doctors and staff seem to treat you the same but you don't seem to have the same options for treatment plans on MA. Some things you are not offered on MA. This is more an issue with dental care than medical care.
>
> Finding a dentist for people on MA is very hard to do. [The] one improvement to be made!
>
> No dentists in our area are accepting MA patients. Very frustrating.

Related to Access to Physicians and Dentists in General

> Because my son has a genetic disease I don't think we have problems getting routine care because the doctors we see are very aware of our issues and accommodate us very well. Personally, I have problems getting good routine care - not my child.
>
> So far we had not really had any problems. Most of the doctors my son sees know him and they are wonderful. I have NO complaints. Thank you.
>
> We go to Broadway Clinic and when I call for an appointment it is usually the same day no hassle at all. The staff very friendly, Dr's very compassionate and easy to understand.
>
> Dentists here don't want to take MA patients because they don't get paid enough. There aren't enough psychiatrists in the area to take care of the number of patients.

They do send you out of town to specialists and the specialists responds right away and do get better care.

In the upper area of MN the care and appointments are not very good. I had to have a doctor in Duluth sign a paper from human services to let them know the care and surgeries I require cannot be done in Bemedji, MN.

People of color are treated different than white people (Native American, Blacks, etc.) often talked to in condescending manner.

All the care I've received in Winona has been far better then what I've received any where else. I'm pleased with all the health care providers here.

We have many hospitals/clinics close. I have no problem getting appointments or any medical coverage. I have a personal nurse that stops at our house every week. Our meds store is only 1 mile from our house.

Dental care is next to impossible to find. Medical care is great! Thank you!

Other Comments

I think it is difficult to get good help but [Medical Assistance] makes it easy to help you.

Would be nice to have own insurance.

I have had very good experience with all my doctors & medical care.

Very grateful. Actually it's easy to get medical care. Thank you and God bless you.

Thank you very much for your help!

Thank you for conducting this survey. I'm grateful, I have a wonderful chiropractor, but I feel bad seeing him because MA only pays half his usual fee.

General Satisfaction

At the end of the survey, members were asked their overall satisfaction related to their experiences getting health care in the Medical Assistance program as well as their perception of the Medical Assistance program compared to private insurance.

Exhibit 9 on the next page shows that, among the survey respondents, over 60 percent stated that they were 'very satisfied' and over 80 percent were either 'very satisfied' or 'somewhat satisfied'. Only 10 percent stated that they were dissatisfied, while the remaining 10 percent either were not sure or did not respond.

A minority of FFS members think that the care they receive in the Medical Assistance program is worse than what they think they would receive with private insurance (18% of total respondents). Exhibit 10 shows that almost three-quarters of respondents (73%) believe that their ability to receive

care in the Medical Assistance program is either the same or better than what they would receive with private insurance.

Exhibit 9

Overall, how satisfied are you with your experiences getting health care in the Medical Assistance program?

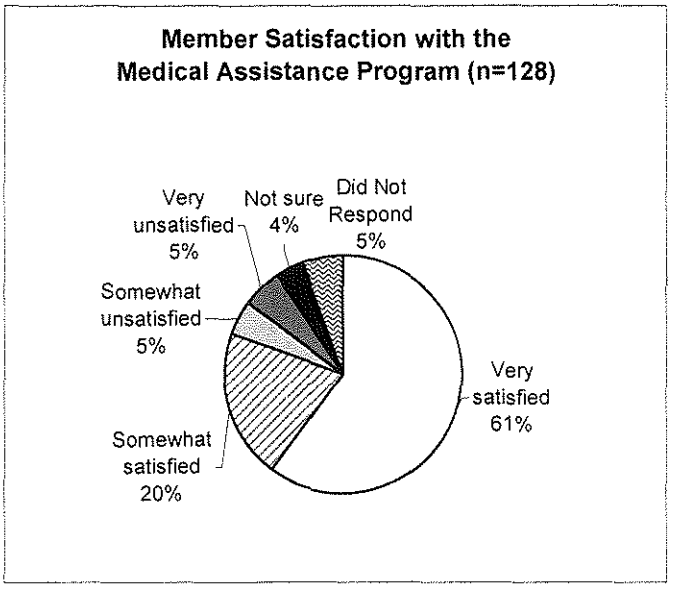
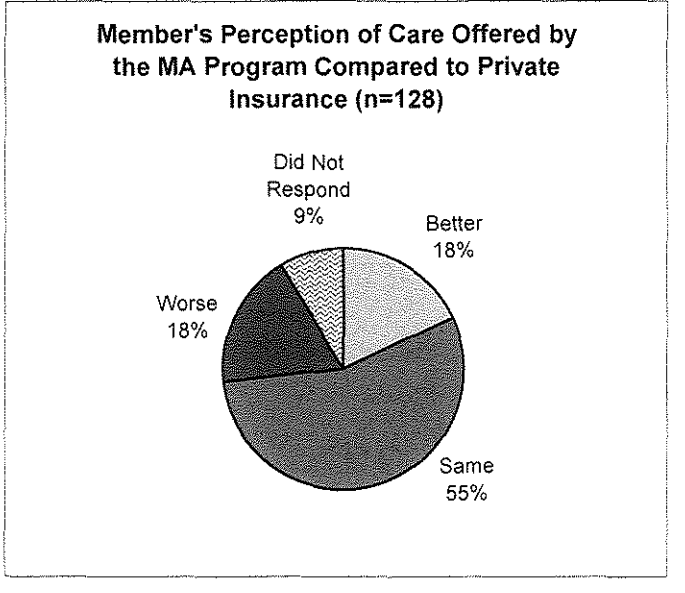


Exhibit 10

Do you think you are able to get care that is better, the same or worse than if you had private insurance?



Physician Survey

Of the 1,100 surveys sent to FFS physicians, 148 were submitted to B&A and 149 were returned to sender. Therefore, of the net 951 surveys sent with a positive address, the response rate was 16 percent. An additional 13 were faxed to B&A by providers who were not sent a survey originally but had expressed interest to the Minnesota Medical Association in participating. The feedback from these surveys has been included in most of the analyses in this section. However, because B&A does not have demographic data for these physicians, the 13 faxed submissions have been excluded from Exhibit 11 below.

A profile of the demographics for the respondents in Exhibit 11 shows that the proportion of respondents by participation level was similar to the total surveyed. Respondents were proportional across the eight regions of the state with the exception of the Southeast Region, which had a lower response rate, and the Southwest Region, which had a higher response rate.

Exhibit 11
Demographics of Respondents to the Physician Survey

	Number of Respondents	Percent of Respondents	Total Surveyed	Percent of Surveyed
Participation Level in FFS				
Active Participation	73	49%	507	53%
Limited Participation	75	51%	444	47%
	148	100%	951	100%
Region				
Northeast	18	12%	88	9%
Northwest	6	4%	46	5%
Central	16	11%	131	14%
West Central	8	5%	31	3%
South Central	14	9%	90	9%
Metro	65	44%	412	43%
Southeast	8	5%	108	11%
Southwest	13	9%	45	5%
	148	100%	951	100%

Although 148 surveys were mailed back to B&A, we ultimately used only 97 surveys for our analysis. The reasons for this are described below.

1. The 13 surveys that were faxed to B&A were added into the analysis, bringing the total to 161 respondents.
2. Physicians were able to offer open-ended feedback at the end of the survey (to be discussed at length later in this section). Many of the physicians who sent back a survey wrote in this feedback section that they did not believe that the survey was applicable to them for reasons such as they have since retired from practice, they work at the state psychiatric hospital, or they are leaving the state. Others only filled in this last question. B&A removed 21 respondents for these reasons.
3. Physicians were asked to describe their practice setting. There were 43 that stated that they primarily work in a hospital setting. Since the majority of the survey was intended to obtain feedback on rates to physicians in an office practice, these respondents were also excluded.

Because only 97 credible responses were received, the findings reported in the remainder of this section should be taken with caution. However, some of the results may provide insight for decisionmakers related to physicians' perceptions of the Medicaid FFS program.

Profile of Respondents Used in the Analysis

Among the 97 respondents used in the analysis, 13% stated that they had a solo practice, 58% stated that they were a member of a group practice, 23% stated that they were a salaried physician, and 5% did not answer the question.

The majority of the respondents participate in both the Medicaid FFS program and the Medicaid managed care program—61% contract with a Medicaid managed care plan, 14% do not contract, and 25% did not answer the question.

Using the B&A criteria to determine 'active' or 'limited' participation in the FFS program, 40 physicians in our analysis were defined as having active participation, 46 were defined as having limited participation, and 11 could not be defined because they were faxed in and we do not have claims data on these providers.

Respondents were asked to estimate the percentage of their business each major payer comprises. For almost half of the respondents used in the analysis, the Medicaid program (both FFS and managed care) represents less than 10% of their total business. Only 11% of the respondents reported that Medicaid was more than 30% of their business.

Exhibit 12
Percent of Respondents' Business by Payer

	Medicaid*	Medicare	Commercial Insurance	State Employees	Charity Care**
Under 10%	47%	47%	31%	95%	87%
11% - 20%	25%	16%	12%	3%	11%
21% - 30%	17%	28%	23%	2%	0%
Greater than 30%	11%	9%	34%	0%	2%
	100%	100%	100%	100%	100%

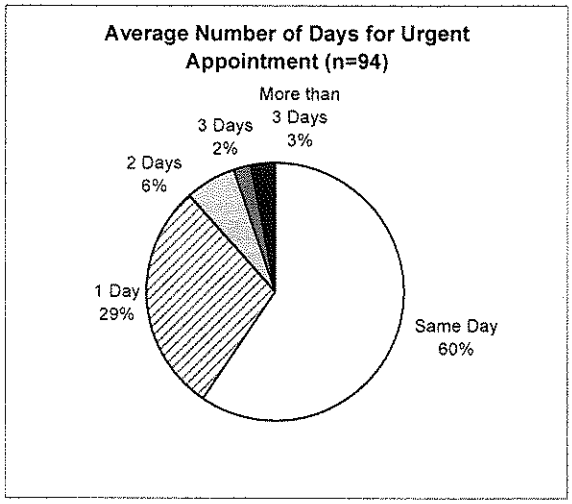
* Includes both fee-for-service and managed care
** Excludes Medicaid

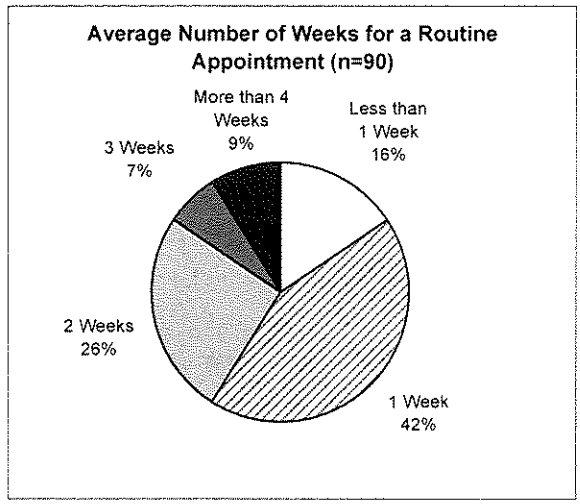
Respondents were also asked if they limit their participation in the Medicaid FFS program. Of the 83 that responded to the question, only seven indicated that they did limit their participation. Of these, six of the seven cited reimbursement rates as the top reason, while missed appointments by members was cited as a secondary reason.

With respect to appointment scheduling, the physicians that responded to the survey provided similar feedback to what was provided by in the member survey. Nine out of 10 physicians indicated that their average wait time for an urgent appointment was one day or less, while 58 percent stated that a routine appointment could be scheduled in one week or less. Refer to Exhibit 13 on the next page for details.

Exhibit 13

What is the average wait time for routine and urgent appointments in your practice (for all patients)?





Feedback on Medicaid FFS Rates

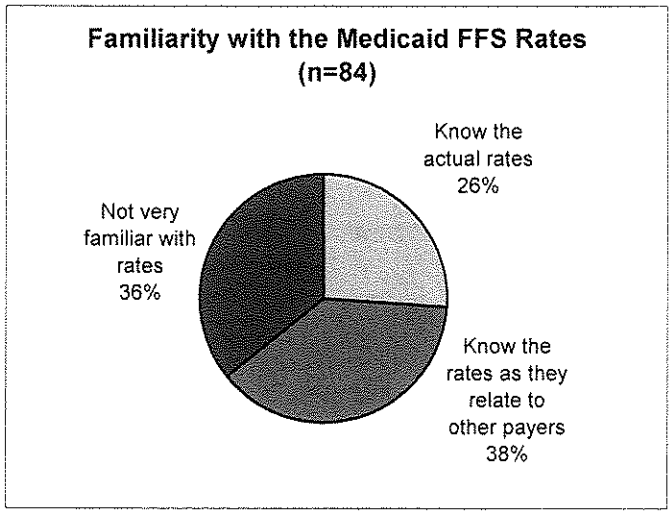
Although this survey yielded only 97 responses for analysis, the one definitive conclusion that appears that can be drawn is near-universal dissatisfaction with reimbursement rates in the FFS program.

First, the physicians were asked for their level of familiarity with the Medicaid FFS rates. A table was provided with the survey listing the rates for 26 common office visit, hospital visit, and medication management services billed by physicians.

Exhibit 14 shows that two-thirds of the respondents either are well aware of the FFS rates or are at least familiar with the FFS rates as they compare to other payers.

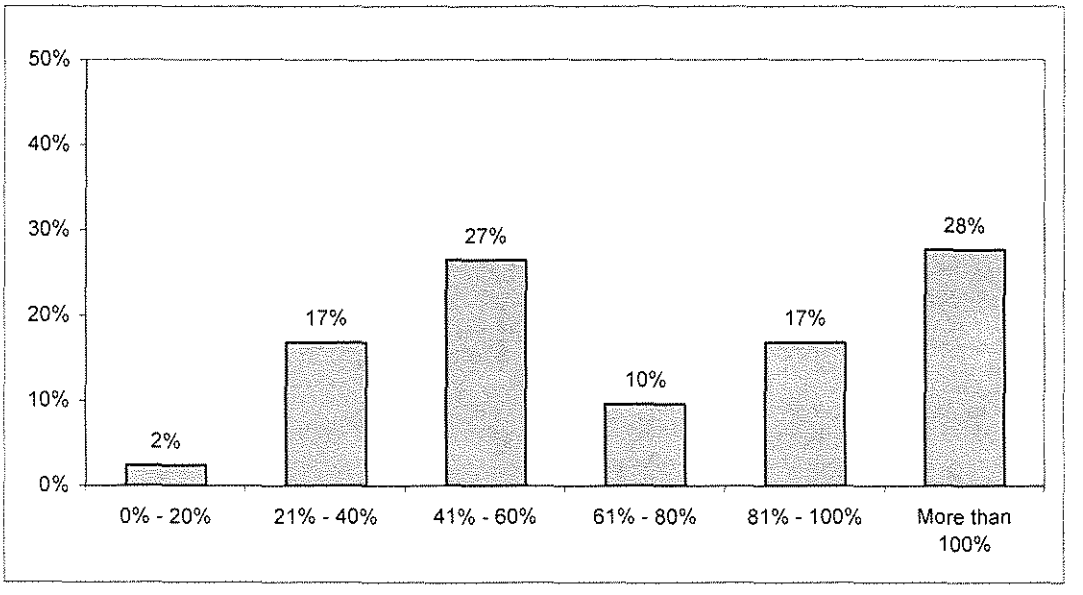
Exhibit 14

Check the box that most accurately represents your familiarity with the Medicaid fee-for-service rates.



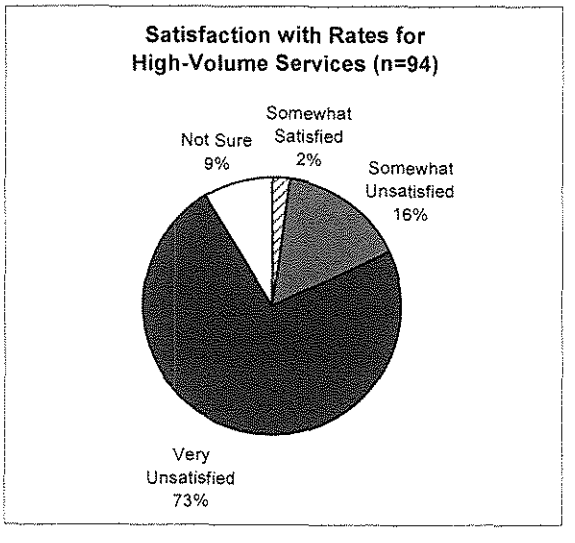
Physicians were asked to review the rate schedule provided and to estimate the level that the rates would need to be increased to cover their costs to deliver the services to Medicaid FFS members. Over one quarter (28%) of the respondents indicated that the rates would need to at least be doubled, while over 80 percent stated that the rates needed to be increased by 40 percent or more.

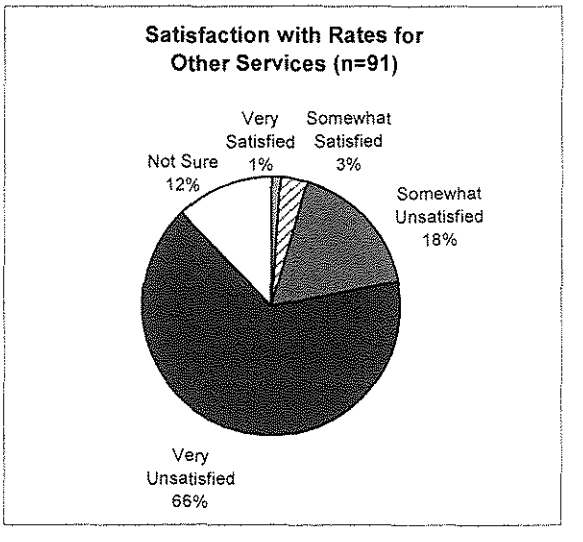
Exhibit 15
Suggested Rate Increase to Cover Physician Costs to Treat Medicaid FFS Recipients (n=83)



When asked for their satisfaction level about the rates shown on the attached rate schedule, 89 percent of the respondents expressed dissatisfaction with the rates and 73 percent were very unsatisfied. For other low-volume rates, the dissatisfaction rate was almost as high at 84 percent. No respondent indicated that they were 'very satisfied' with the rates for high-volume services, and only one respondent stated this for the low-volume service rates.

Exhibit 16
How would you describe your satisfaction with the rate of reimbursement paid by Medicaid fee-for-service?

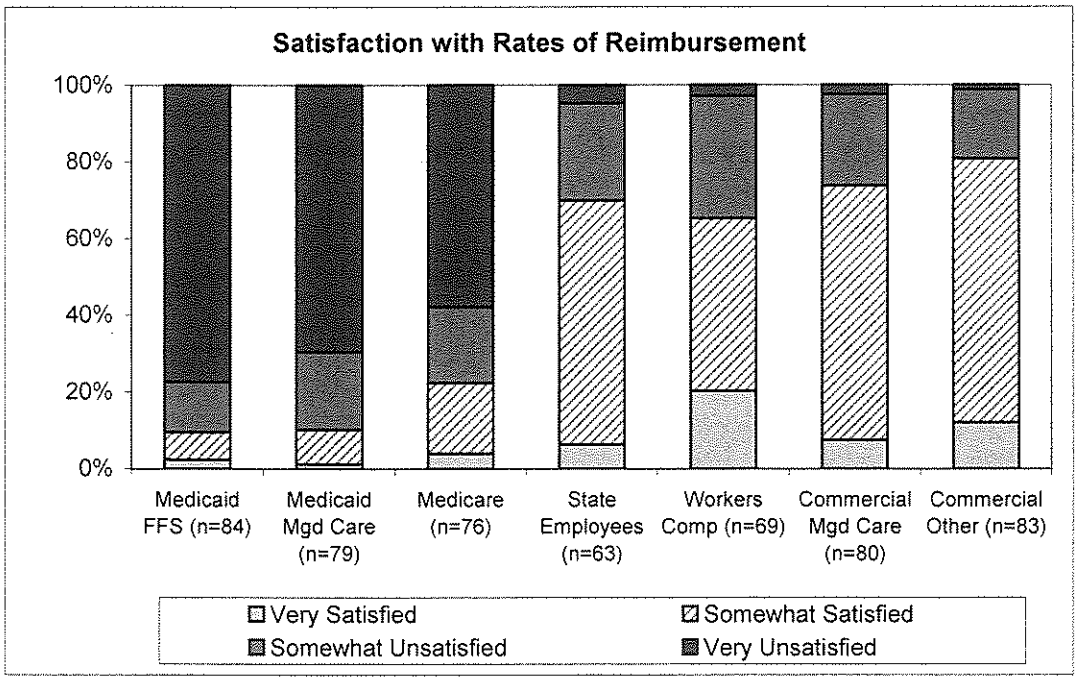




Physicians were also asked to provide their opinion on Medicaid FFS rates overall as compared to other payers. Among the various payers queried, the Medicaid FFS program had the highest level of dissatisfaction (77% very unsatisfied and 13% somewhat unsatisfied), but the Medicaid managed care program was at almost the same level of dissatisfaction (70% very unsatisfied and 20% somewhat unsatisfied). This contrasts with the satisfaction levels of commercial payers. Physicians rated their satisfaction level with commercial managed care rates (very or somewhat satisfied) at 74 percent and with non-managed care commercial rates at 81 percent. The satisfaction for rates paid by the state for the state employee benefit program was also high (70% very or somewhat satisfied).

Exhibit 17

How would you describe your satisfaction with the rate of reimbursement you receive from each of the following?



B&A also studied the satisfaction levels of reimbursement across different categories of provider participation in the Medicaid FFS program. Those physicians most active in the program had higher levels of dissatisfaction than those with more limited participation.

Exhibit 18

Satisfaction with Medicaid FFS Rates by Level of Participation

Participation Group in Medicaid FFS	Number Responding to Question	Very Unsatisfied	Somewhat Unsatisfied	Somewhat Satisfied	Very Satisfied
Active Participation	n = 34	88%	9%	3%	0%
Limited Participation	n = 40	63%	20%	13%	5%
Unknown*	n = 10	100%	0%	0%	0%
Overall	**n = 84**	**77%**	**13%**	**7%**	**2%**

* unsolicited surveys received by fax

The level of dissatisfaction was not unexpected given the lack of rate increases in the last 17 years. Because it was anticipated that physicians would suggest that rates would need to be increased considerably, the respondents were asked, given the potential limitation of funding to enact a fully-desired increase, if there were specific services that should receive attention first. Respondents were asked to provide the name of a service or specific codes that they would suggest receive priority. There were 79 respondents who provided suggestions, which can be divided across these main categories:

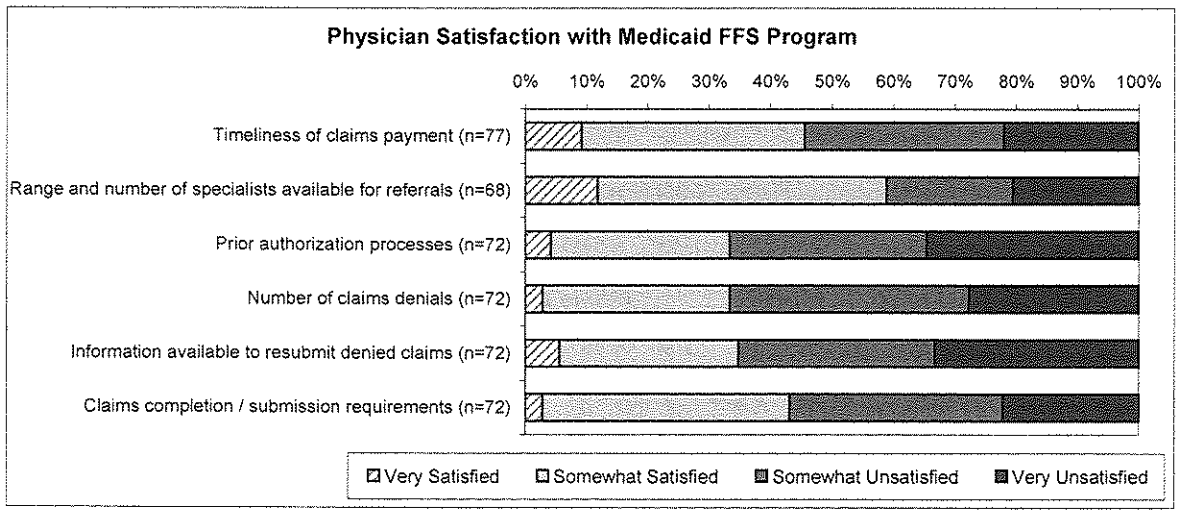
- 45 suggested the evaluation and management (E&M) codes, which are the high-volume service codes delivered by primary care providers. Within this group, 31 suggested the most common series of office/outpatient visit codes (CPT 99201-99215).
- 14 merely stated "All", citing no particular priority
- 20 suggested a variety of other services, including OB/GYN and prenatal care services, anesthesia, behavioral medication and lab tests

Feedback on Other Aspects of the Medicaid FFS Program

Although this survey was mostly intended to gain feedback on reimbursement rates, physicians were also asked about their satisfaction with other aspects of the FFS program. Four questions were asked about billing, one about prior authorization, and one about referrals. None of the items received a satisfaction rating above 50 percent except for 'range and number of specialists available for referrals' which received a 59 percent satisfaction rating ('very satisfied' and 'somewhat satisfied' combined). Items related to prior authorizations and claims denials each received a dissatisfaction rating among 67 percent of the respondents ('very unsatisfied' and 'somewhat unsatisfied' combined).

Exhibit 19

How would you describe your satisfaction with the following related to the Medicaid fee-for-service program?

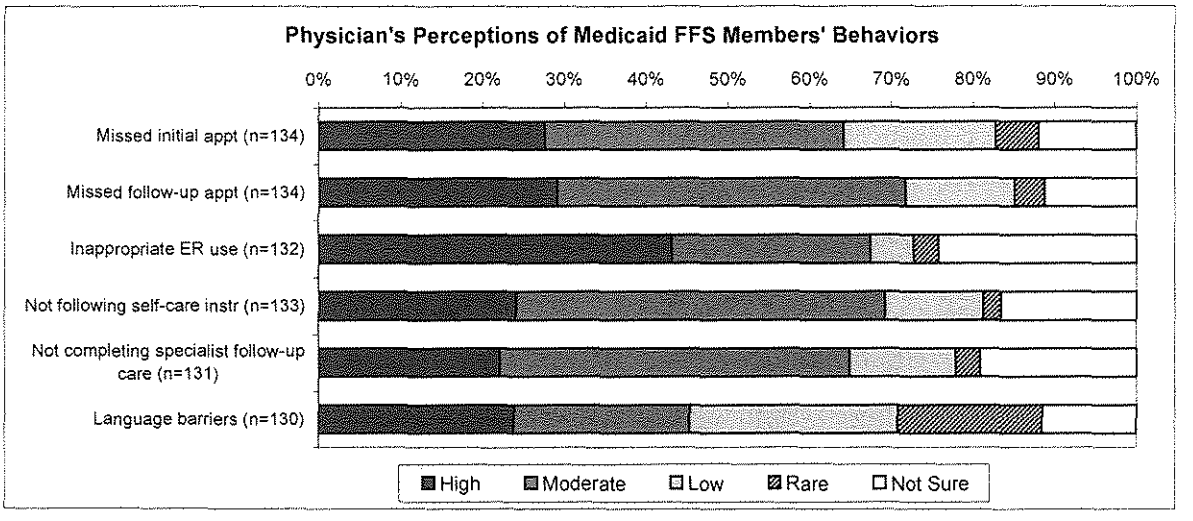


Physicians were also asked to comment about Medicaid FFS member behaviors. The hospitalists who had been excluded from all of the other analyses were included in Exhibit 20 below since the questions were not related to reimbursement and billing. Therefore, the total sample could include up to 140 respondents, though some physicians did not comment on each of the items shown below.

The area of most concern expressed by the physicians was members' inappropriate use of the ER (43% stated that ER use was 'high'). Two-thirds of the physicians, however, stated that members had 'high' and 'moderate' adverse behavior for each item listed in Exhibit 20 with the exception of language barriers.

Exhibit 20

To the best of your knowledge, please check the frequency of the following among your Minnesota Medicaid fee-for-service patients.



Qualitative Comments

Respondents were given the opportunity to comment on any other aspects of the Medicaid program that they would like to mention. They were encouraged to mention any strategy that would increase their participation in the program. Of the 140 respondents (including the hospitalists), 75 provided some type of qualitative feedback. The comments can be categorized into the following topics as shown in Exhibit 21.

Exhibit 21
Categories of Qualitative Comments Submitted by Physicians

Topic	Number Commenting	Percent of All Respondents
Reimbursement too low	40	29%
No Shows a problem	11	8%
Will reduce number of MA patients	10	7%
Do revenue sharing to increase participation	6	4%
Too much bureaucracy	4	3%
Need patient co-pays	4	3%
Need to better educate members	4	3%

Examples of Specific Comments Related to Reimbursement

Reimbursement rates are so low for MA that they do not even cover overhead, much less pay for my work as the physician. Other than my empathy for my patients I have absolutely no incentive to see MA patients. (excerpt from a long letter that was included with the survey)

We will have to start limiting the number of MA patients within our practice if reimbursement does not increase.

Better reimbursement. Shame on you.

Payment is the key. These rates are $20.00/RVU and our cost is $50.00/RVU. Payment must cover cost.

Current reimbursement levels do not cover overhead even if I worked for free. It would be better for me financially to hand out $100 bills to Medicaid patients and ask them to go elsewhere.

Rates have to increase substantially or we will need to look at terminating our MA contracts. We are hanging on by a thread and the amount of patients that are on MA is increasing.

Reimbursement for anesthesia is disgraceful. There has been no increase for at least 17 yrs. If we were not hospital based, we would not treat patients with Medicaid. We lose money on every Medicaid patient.

Extremely unsatisfactory program for reimbursement. Would prefer providing free care to a percentage of indigent patients.

Increase in fee schedule & some form of reimbursement for "no show" Medicaid patients.

It's thoroughly unreasonable to expect physicians to provide high quality medical care for reimbursements that would embarrass & infuriate a plumber.

Our office staff does not consider type of insurance when scheduling appointment. However, you need to seriously consider how these patients get treatment when reimbursement doesn't cover the doctor's overhead. Why did you eliminate the patient's office co-pay?

Full payment for interpreter services.

Examples Related to Patient Behavior

These patients need to be educated better. They often don't understand they have month-to-month coverage. Some have $3 co-pays, they very often have no ID card or the wrong ID card. We are fortunate that we don't have a higher number of these patients.

We may begin limiting due to poor reimbursement. All Medicaid should have a co-pay - $10 or $20 for office visit, $50 for ER. Would encourage appropriate use of medical care & limit unnecessary visits.

Patient education not to abuse ER. Higher out of pocket cost for ER co-pays.

At present, absolutely NO mechanism exists for reporting patients that abuse/misuse the MA system.

Other Comments

Have an annual COLA increase, reduce prior authorization requirements. For children with chronic conditions, payments for pediatric services [should be] at higher rate due to additional coordination communication needed. Exclude MA receipts from provider tax.

Program lacks appropriate services to providers yet they fund the program through MN care taxes. If you want more participation, cut out the bureaucracy and pay physicians more!

No taxes on care provided.

1. Increase the quality of customer service to providers.
2. Make timely claims payments.
3. Better educate the eligible on their benefits.
4. Allow clinics to enforce collection policies to those patients whom you place on spenddown.

Very unsatisfied with the amount of time it takes to reprocess denials.

We would propose paying for innovative approaches to health care delivery such as e-consults (ie. Medical record reviews), phone calls, online visits, telemedications, etc. This could potentially help ensure access to necessary services at a lower cost.

SECTION IV: RECOMMENDATIONS

The intent in surveying a sample of Medicaid FFS members and providers was to gain on-the-ground feedback related to topics previously analyzed in other reports that have been submitted by Burns & Associates (B&A) for this engagement. Although the sample of respondents was small, particularly for the provider survey, the feedback from both the members and the physicians supported many of the topics studied. In summary:

- It was generally found that members' access to physicians in the FFS program was sufficient, though there may be pockets in the northern counties of the state where access may be compromised. This was supported by members' feedback on the survey reporting reasonable wait times to make an appointment for urgent care and routine care.

- The only provider type for which there appears to be access concerns in multiple parts of the state is for dentists.

- Physicians almost universally believe that their reimbursement is very unsatisfactory in the Medicaid FFS program. Their level of satisfaction was lowest for Medicaid FFS when compared to other payers as well. Although few have stated that they have outright limited the number of FFS patients that they will accept, many reported that they are considering it.

- Over one quarter (28%) of the physicians indicated that their rates would need to at least be doubled, while over 80% stated that the rates needed to be increased by 40 percent or more, just to cover their costs. The majority of physicians that provided specific areas for rate increases stated that the high-volume evaluation and management services should be given highest priority. These comments are supported by a recent national study which showed that Minnesota ranked 43rd among Medicaid agencies for its payment for primary care services and 45th for obstetrical services. When compared to Medicare rates, Minnesota fares equally poorly for primary care and obstetrical services, but is ranked high compared to other states for non-primary, non-OB services.

In light of these findings and the feedback from its constituents, B&A recommends that the Minnesota Department of Human Services (DHS) adopt the Medicare Resource-Based Relative Value Scale (RBRVS) as per Legislative mandate. Resources should be put towards implementation of this system as a base for further rate changes. The RBRVS system is a national standard of reimbursement that virtually all physicians understand, is regarded as having equitable resource use factors for the various physician services, and is relatively easy to administer.

Since it is unlikely in the current economic situation that the state can afford physician payments at the Medicare rates, the conversion factor that is used in the RBRVS system should be set at a level that will be budget neutral overall. However, B&A recommends that the state adopt a policy goal of compensating physicians at a specified level, such as 85% of the Medicare rates. As funding becomes available, the conversion factor can be increased accordingly to meet this target.

As a policy matter, the DHS may want to adopt a higher conversion factor for "high value" services, which we recommend should initially include evaluation and management physician services as well as obstetrical/prenatal care services. This will encourage participation among primary care physicians and can help towards the long-term goal of reducing inappropriate ER use.

APPENDIX A

MINNESOTA MEDICAID SURVEY ON ADEQUACY OF RATES

The Minnesota Department of Human Services' Medicaid program was asked by the Legislature to evaluate whether the rates it pays providers in the fee-for-service portion of the program are adequate to ensure that Medicaid recipients can access appropriate and timely medical care. This survey pertains to the fee-for-service program only, where the state pays providers directly for services on behalf of recipients who are not enrolled in managed care. One component of the evaluation is a survey of physicians to obtain their feedback on the adequacy of the fee-for-service rates.

The state would like to encourage more participation in the program either by increasing the number of Medicaid individuals served by currently participating physicians and/or by increasing the number of overall physicians participating in the program. We are surveying providers in the state who are considered both high-volume and low-volume with respect to serving the Medicaid fee-for-service program to obtain their feedback.

Your responses will be confidential. The code that appears at the bottom is so that we can track respondents in case a follow-up mailing is required. We encourage you to provide comments in the space provided in Questions #14 and #15 for open-ended feedback. Many questions on this survey may be more appropriate for office managers to complete. Feel free to have them complete the questions that they may be knowledgeable on.

The results of this survey, as well as other evaluation findings, will be available in a public report scheduled for release in May 2009. Your participation is greatly appreciated. Please return your completed survey form by ***March 26, 2009*** in the self-addressed stamped envelope. If the envelope that has been included with this survey gets lost, please send your response back to our independent evaluators:
"Burns & Associates Minnesota Physicians Survey", P.O. Box 418, Clifton Park, NY 12065 or fax it to them at (518) 899-0124.

1. Check below what best describes your practice.
   - ❑ Solo practice ❑ Member of a group office practice ❑ Salaried physician- any setting
   - ❑ Production-based physician primarily practicing in a clinic/hospital If yes, what % production-based? ____

2. Indicate the total of full-time employees in the office/clinic here _____. The number by profession is:
   _____ Physicians _____ Mid-level (e.g. nurses, physician assistants) _____ Admin/ clerical

3. Do you contract with a Minnesota Medicaid managed care plan? ___Yes ___No

4. Estimate the percentage of your practice represented by the following groups:

Medicaid fee-for-service	_____%	Medicaid managed care	_____%
Medicare	_____%	Commercial insurance	_____%
State employees	_____%	Charity Care*	_____%
All other	_____%		

*Low Income individuals outside of Medicaid you serve for zero or a nominal charge

5. How would you describe your satisfaction with the rate of reimbursement you receive from each of the following?

	Very Satisfied	Somewhat Satisfied	Somewhat Unsatisfied	Very Unsatisfied	Not Sure or N/A
a. Medicaid fee-for-service	❑	❑	❑	❑	❑
b. Medicaid managed care	❑	❑	❑	❑	❑
c. Medicare	❑	❑	❑	❑	❑
d. State Employees/Teachers	❑	❑	❑	❑	❑
e. Workers Compensation	❑	❑	❑	❑	❑
f. Commercial- Managed Care	❑	❑	❑	❑	❑
g. Commercial Insurance- Other	❑	❑	❑	❑	❑

Please turn the page over

6. How would you describe your satisfaction with the rate of reimbursement paid for the following services by Medicaid fee-for-service?

	Very Satisfied	Somewhat Satisfied	Somewhat Unsatisfied	Very Unsatisfied	Not Sure or N/A
a. Services shown in the table on the next page	❑	❑	❑	❑	❑
b. All other services not shown in the table	❑	❑	❑	❑	❑

7. How would you describe your satisfaction with the following related to the Medicaid fee-for-service program?

	Very Satisfied	Somewhat Satisfied	Somewhat Unsatisfied	Very Unsatisfied	Not Sure or N/A
a. Timeliness of claims payment	❑	❑	❑	❑	❑
b. Range and number of specialists available for referrals	❑	❑	❑	❑	❑
c. Prior authorization processes	❑	❑	❑	❑	❑
d. Number of claims denials	❑	❑	❑	❑	❑
e. Information available to resubmit denied claims	❑	❑	❑	❑	❑
f. Claims completion/submission requirements	❑	❑	❑	❑	❑

8. To the best of your knowledge, please check the frequency of the following among your Minnesota Medicaid fee-for-service patients.

	High	Moderate	Low	Rare	Not Sure
a. Missed appointments for initial visits	❑	❑	❑	❑	❑
b. Missed appointments for follow-up visits	❑	❑	❑	❑	❑
c. Inappropriate use of emergency rooms	❑	❑	❑	❑	❑
d. Not following instructions for self-care	❑	❑	❑	❑	❑
e. Not completing follow-up care with specialists	❑	❑	❑	❑	❑
f. Language barriers	❑	❑	❑	❑	❑

9. What is the average wait time for routine and urgent appointments in your practice (for all patients)?

_____ days for an urgent appointment _____ weeks for a routine appointment

10. Do you limit your participation in the Medicaid fee-for-service program?

❑ Yes (*proceed to Question 11*) ❑ No (*proceed to Question 12*)

11. If you answered 'Yes' to Question #10, identify the top 3 factors contributing to your decision to limit your participation in Medicaid fee-for-service. Place the number 1 (highest importance), 2 (next highest), and 3 (third highest) next to the factors you consider the most important to your decision to limit your participation.

	Ranking of Importance
a. Rates paid for services	_____
b. Delay/problems with getting paid	_____
c. Missed appointments by patients	_____
d. Inappropriate use of health care by patients	_____
e. You are not accepting new patients	_____
f. Authorization difficulties	_____
g. Not enough specialists to refer patients	_____
h. Other (describe)	_____
i. Other (describe)	_____

If you indicated that one of your most important issues is not enough specialists to refer patients, are there particular specialty areas that are insufficient? _____

12. Check the box that most accurately represents your familiarity with the Medicaid fee-for-service rates.
    ❑ Know the actual rates ❑ Know the rates as they relate to other payers ❑ Not very familiar with rates

13. Please review the table below for the current Medicaid fee-for-service rates for high-volume services and consider your own knowledge of the Medicaid fee-for-service rates you are paid. Please estimate how much the rates would need to increase to at least cover your costs to treat Medicaid recipients?

    ❑ 0-20% ❑ 21%-40% ❑ 41-60% ❑ 61-80% ❑ 81-100% ❑ More than 100%

CPT	Description	Medicaid FFS Rate (w/o modifiers)
90862	Medication Management	$60.48
99201	Office/Outpatient Visit, New Pat, 10 min	$27.19
99202	Office/Outpatient Visit, New Pat, 20 min	$30.48
99203	Office/Outpatient Visit, New Pat, 30 min	$36.25
99204	Office/Outpatient Visit, New Pat, 45 min	$61.80
99205	Office/Outpatient Visit, New Pat, 60 min	$90.64
99211	Office/outpatient visit, est. patient, 5 min	$12.36
99212	Office/outpatient visit, est. patient, 10 min	$20.60
99213	Office/outpatient visit, est. patient, 15 min	$24.72
99214	Office/outpatient visit, est. patient, 25 min	$46.14
99215	Office/outpatient visit, est. patient, 45 min	$65.92
99221	Initial hosp care, physician bedside, 30 min	$54.07
99222	Initial hosp care, physician bedside, 50 min	$100.42
99223	Initial hosp care, physician bedside, 70 min	$112.01
99231	Subseq hosp care, physician bedside, 15 min	$30.12
99232	Subseq hosp care, physician bedside, 25 min	$34.76
99233	Subseq hosp care, physician bedside, 35 min	$92.70
99242	Office Consultation, 30 min	$60.25
99243	Office Consultation, 40 min	$78.79
99244	Office Consultation, 60 min	$113.55
99245	Office Consultation, 80 min	$135.18
99253	Initial Inpatient Consultation, 55 min	$78.79
99254	Initial Inpatient Consultation, 80 min	$113.55
99255	Initial Inpatient Consultation, 110 min	$135.18
99283	Emergency Dept. Visit, mid-level	$37.46
99284	Emergency Dept. Visit, mid-level	$50.98

14. If it is determined that funds are limited to increase all provider rates, are there specific services or specialty types for which the fee-for-service rates paid by Medicaid are particularly inadequate? Please describe the service or specialty type or provide the CPT code below.

    _____

    _____

15. Please describe any other strategy that would begin or increase your participation in Medicaid. Also use this space to add comments related to other questions on the survey.

    _____

    _____

    _____

Thank you for your participation

APPENDIX B

Minnesota Department of Human Services

Medical Assistance Member Survey
Access to Medical Care

The Minnesota Department of Human Services wants to find out if people on fee-for-service Medical Assistance can get medical care near where they live, when they need it. Members can use any doctor in their area that will see fee-for-service Medical Assistance patients. Fee-for-service is the part of the program for members who are not enrolled in a health plan.

We are asking you to complete this survey because you are in fee-for-service Medical Assistance and you used some health care services in the last year. Your responses will be confidential. Please write comments in Question 12 if there are things we did not ask that you want us to know about. The survey results will be included in a report that will be available on the DHS Web site later this spring. No individual names will be mentioned in the report. Thank you for your help.

Please return your completed survey by ***March 30, 2009*** in the self-addressed stamped envelope. If the envelope gets lost, please send your response to our survey firm:
Burns & Associates Minnesota Physicians Survey, PO Box 418, Clifton Park, NY 12065.

If the survey is addressed to your child, please answer on their behalf and place a ☑ in this box. ❒

1. Do you have a personal doctor or nurse that you see most of the time when you need care? ❒ Yes ❒ No
   If you answered No, do you go to a clinic most of the time? ❒ Yes ❒ No

2. Since last July, how many times did you visit the following for care? (*Check the box next to your answer*)

   a. Your primary doctor (in an office or clinic) ❒ Zero ❒ Once ❒ Twice ❒ 3 times ❒ More than 3

   b. Another doctor where your primary doctor works ❒ Zero ❒ Once ❒ Twice ❒ 3 times ❒ More than 3

   c. A different doctor's office or clinic ❒ Zero ❒ Once ❒ Twice ❒ 3 times ❒ More than 3

3. If you checked more than zero in any of the questions in #2 above, how long did you have to wait for an appointment when you needed care **right away** at (*fill out those that apply*)

   a. The office/clinic where your primary doctor works? ❒ 1 day ❒ 2 days ❒ 3-4 days ❒ 5-6 days ❒ More than 6

   b. A different doctor's office or clinic you visited? ❒ 1 day ❒ 2 days ❒ 3-4 days ❒ 5-6 days ❒ More than 6

4. If you needed care right away and you thought the wait for an appointment was too long, did you go instead to:

   a. The emergency room? ❒ Yes ❒ No If Yes, how many times since July? _____

   b. An urgent care center? ❒ Yes ❒ No If Yes, how many times since July? _____

   c. Retail clinic in a store? ❒ Yes ❒ No If Yes, how many times since July? _____

5. On average, how long did you have to wait for a checkup or **routine appointment** at (*fill out those that apply*)

   a. The office or clinic where your primary doctor works?
      ❒ Less than 1 week ❒ 1-2 weeks ❒ 2-3 weeks ❒ 3-4 weeks ❒ More than 4 weeks

   b. A different doctor's office or clinic?
      ❒ Less than 1 week ❒ 1-2 weeks ❒ 2-3 weeks ❒ 3-4 weeks ❒ More than 4 weeks

Please turn the page over

6. When you went for your appointment, how long after your appointment time did you wait to see the doctor at (*fill out those that apply*)
   a. The office or clinic where your primary doctor works?
      ❒ 15 minutes or less ❒ 16-30 minutes ❒ 31-45 minutes ❒ 46-60 minutes ❒ More than 1 hour

   b. A different doctor's office or clinic?
      ❒ 15 minutes or less ❒ 16-30 minutes ❒ 31-45 minutes ❒ 46-60 minutes ❒ More than 1 hour

7. Did you need to see a specialist since July 1, 2008? ❒ Yes ❒ No
   If Yes, answer the questions below. If No, go to Question #8.

Check the box if you have needed a service from this type of doctor since July ↓		For any doctor you put a check next to, check the box below that indicates how long it took you to get an appointment
a. OB GYN/ Maternity	❒	❒ Less than 1 week ❒ 1-2 weeks ❒ 2-3 weeks ❒ 3-4 weeks ❒ More than 4
b. Psychiatrist	❒	❒ Less than 1 week ❒ 1-2 weeks ❒ 2-3 weeks ❒ 3-4 weeks ❒ More than 4
c. Cardiologist	❒	❒ Less than 1 week ❒ 1-2 weeks ❒ 2-3 weeks ❒ 3-4 weeks ❒ More than 4
d. Neurologist	❒	❒ Less than 1 week ❒ 1-2 weeks ❒ 2-3 weeks ❒ 3-4 weeks ❒ More than 4
e. Orthopedic surgeon	❒	❒ Less than 1 week ❒ 1-2 weeks ❒ 2-3 weeks ❒ 3-4 weeks ❒ More than 4

8. Please check the level of difficulty in finding a personal doctor, specialist or dentist.

	Big problem	Small problem	No problem	Did not try to find one
a. Personal doctor or nurse	❑	❑	❑	❑
b. OB GYN/ Maternity	❑	❑	❑	❑
c. Psychiatrist	❑	❑	❑	❑
d. Pediatrician	❑	❑	❑	❑
e. Dentist	❑	❑	❑	❑
f. Cardiologist	❑	❑	❑	❑
g. Neurologist	❑	❑	❑	❑
h. Orthopedic surgeon	❑	❑	❑	❑

9. If you had difficulty finding a doctor or dentist, why was it difficult? Check the two that are the most important.

   ❑ The doctors/dentists would not see me because I have Medical Assistance.
   ❑ The doctors'/dentists' were not taking new patients.
   ❑ There are no doctors/dentists who speak my language.
   ❑ Where I live, there are just not enough doctors/dentists for the people who live here.

10. Overall, how satisfied are you with your experiences getting health care in the Medical Assistance program?

    ❑ Very satisfied ❑ Somewhat satisfied ❑ Somewhat unsatisfied ❑ Very unsatisfied ❑ Not sure

11. Do you think you are able to get care that is better, the same or worse than if you had private insurance?

    ❑ Better ❑ Same ❑ Worse

12. Please comment or give examples on any of the questions above or on how easy/difficult it is to get medical care.

    _____

    _____

    _____

ion. If you want free help translating this information, call (651) 431-2670 or (800) 657-3739.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم 2670-431 (651) أو 3739-657 (800).

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ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣ໌ຫາ (651) 431-2670 ຫຼື (800) 657-3739.

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Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al (651) 431-2670 o (800) 657-3739.

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